

8094

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>		d. STREET ADDRESS <u>4974 QUEBEC ST NW</u>	
3. NAME OF DECEASED (Type or print) <u>JASPER</u> First <u>NATHAN</u> Middle <u>BAKER</u> Last		4. DATE OF DEATH <u>July 10</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1865</u> 93 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RTD</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BOONVILLE, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Link</u>		14. MOTHER'S MAIDEN NAME <u>Link</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wyrth Post Baker - above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30</u> to <u>July</u> 19 <u>59</u> , that I last saw the deceased alive on <u>July 9</u> 19 <u>59</u> , and that death occurred at <u>12:53 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1635 Harvard St Washington D.C.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Wyrth Post Baker</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WYRTH POST BAKER</u>		ADDRESS <u>Washington D.C.</u>	
22a. BURIAL (CREMATION, REMOVAL) (Specify)	22b. DATE THEREOF <u>7-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Thompson</u>		24a. REC'D BY REGISTRAR <u>JUL 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ANN
BOND

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place		16. Name of interment place	
17. Name of next of kin		18. Name of executor		19. Name of administrator		20. Name of guardian	
21. Name of trustee		22. Name of agent		23. Name of attorney		24. Name of clerk	
25. Name of judge		26. Name of jury		27. Name of witness		28. Name of jury	
29. Name of witness		30. Name of jury		31. Name of witness		32. Name of jury	
33. Name of witness		34. Name of jury		35. Name of witness		36. Name of jury	
37. Name of witness		38. Name of jury		39. Name of witness		40. Name of jury	
41. Name of witness		42. Name of jury		43. Name of witness		44. Name of jury	
45. Name of witness		46. Name of jury		47. Name of witness		48. Name of jury	
49. Name of witness		50. Name of jury		51. Name of witness		52. Name of jury	
53. Name of witness		54. Name of jury		55. Name of witness		56. Name of jury	
57. Name of witness		58. Name of jury		59. Name of witness		60. Name of jury	
61. Name of witness		62. Name of jury		63. Name of witness		64. Name of jury	
65. Name of witness		66. Name of jury		67. Name of witness		68. Name of jury	
69. Name of witness		70. Name of jury		71. Name of witness		72. Name of jury	
73. Name of witness		74. Name of jury		75. Name of witness		76. Name of jury	
77. Name of witness		78. Name of jury		79. Name of witness		80. Name of jury	
81. Name of witness		82. Name of jury		83. Name of witness		84. Name of jury	
85. Name of witness		86. Name of jury		87. Name of witness		88. Name of jury	
89. Name of witness		90. Name of jury		91. Name of witness		92. Name of jury	
93. Name of witness		94. Name of jury		95. Name of witness		96. Name of jury	
97. Name of witness		98. Name of jury		99. Name of witness		100. Name of jury	

8095

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>V</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Rockville 7 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Waverly Sanatorium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RENE</i> Middle <i>W.</i> Last <i>BARR</i>		4. DATE OF DEATH Month <i>July</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 23, 1974</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. UNDER 1 YEAR IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Henry D. Barr</i>		14. MOTHER'S MAIDEN NAME <i>Lucene B. York</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Arteriosclerotic Heart Disease</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>5 years</i> <i>15 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 14, 1958</i> to <i>July 5, 1959</i> , that I last saw the deceased alive on <i>July 4, 1959</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wheeler O. Huff</i>		DATE SIGNED <i>4529-Maple Ave, Bethesda, Md.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>7/8/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Calver Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Landover, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lawrence Sons Inc.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>1736 Pa Ave NW Wash. D.C.</i>		DATE <i>JUL 9 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

8086

CERTIFICATE OF DEATH

Reg. Dist. No.

18048

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1618 Farragut Ave.</u>				d. STREET ADDRESS <u>1618 Farragut Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>C.</u> Last <u>Bean</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Scranton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Bean</u>				14. MOTHER'S MAIDEN NAME <u>Race Burkhardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>John F. Bean - Son - Same 2d</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic H. Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> 19 <u>59</u> , to <u>July 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sydney C. May</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd</u> DATE SIGNED <u>7/18/59</u>			
PHYSICIAN'S NAME (Type) <u>Herman C. Kaganzini</u>				<u>Rockville, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shady Lane Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chinchilla, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10082

Male
Age 100
Date of Birth 1812
Date of Death 1912
Cause of Death
Place of Birth
Place of Death
Signature
Date

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8096

CERTIFICATE OF DEATH

Reg. Dist. No. 08049

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>806 Aspen St. NW</u>			
3. NAME OF DECEASED (Type or print) <u>B. Clara</u> First <u>Clara</u> Middle <u>NMN</u> Last <u>Bötze</u>				4. DATE OF DEATH <u>7</u> Month <u>24</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-5-79</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>24</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Jane Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Cardiac Failure</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several years?</u> <u>years?</u> <u>years?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>July 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>59</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Jakoma Park, Md.</u> DATE SIGNED <u>7/24/59</u> ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D. <u>Robert A. Hare M.D.</u> PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 27, 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soeffel Fun. Home 38 & H NW</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thrane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

8097

8097

CERTIFICATE OF DEATH

08050

Reg. Dist. No. 215

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

051

2

1

DP

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda d. STREET ADDRESS 5904 Grosvenor Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jeannette Regina BIONDI		4. DATE OF DEATH Month Day Year July 11 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-78
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Broadus DYE		14. MOTHER'S MAIDEN NAME Margaret PROCTOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT (D) Mrs. Jack P. Pollock, same as #2 above	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerosis, Coronary arteries DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18. INTERVAL BETWEEN ONSET AND DEATH 1 week		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 , 19 59 , to July 11 , 19 59 that I last saw the deceased alive on July 10 , 19 59 , and that death occurred at 12:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-11-59			
ACTUAL SIGNATURE H. E. Richardson		M.D. U. S. Naval Hospital	
PHYSICIAN'S NAME (Type) H. E. RICHARDSON CAPT MC USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Pa. Ave., NW, Wash. DC		24a. REC'D BY REGISTRAR Jul 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

1. (a) $\frac{1}{2}$ (b) $\frac{1}{2}$ (c) $\frac{1}{2}$ (d) $\frac{1}{2}$ (e) $\frac{1}{2}$ (f) $\frac{1}{2}$ (g) $\frac{1}{2}$ (h) $\frac{1}{2}$ (i) $\frac{1}{2}$ (j) $\frac{1}{2}$ (k) $\frac{1}{2}$ (l) $\frac{1}{2}$ (m) $\frac{1}{2}$ (n) $\frac{1}{2}$ (o) $\frac{1}{2}$ (p) $\frac{1}{2}$ (q) $\frac{1}{2}$ (r) $\frac{1}{2}$ (s) $\frac{1}{2}$ (t) $\frac{1}{2}$ (u) $\frac{1}{2}$ (v) $\frac{1}{2}$ (w) $\frac{1}{2}$ (x) $\frac{1}{2}$ (y) $\frac{1}{2}$ (z) $\frac{1}{2}$

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8087

CERTIFICATE OF DEATH

08051

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RYAN Middle E. Last BITTNER		4. DATE OF DEATH Month July Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 25 Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY Auto Mechanic	
13. BIRTHPLACE (State or foreign country) Penna.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Samuel S. Bittner		16. MOTHER'S MAIDEN NAME Henrietta Coleman	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 578-07-7872	
19. INFORMANT Marie S. Bittner - Item #2 - Wife		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Emphysema DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May, 1959 to 7-23, 1959 , that I last saw the deceased alive on 7-22, 1959 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. G. Hall		ADDRESS (Street, city or town, state) DATE SIGNED 615 W. Montgomery Ave. Rockville, MD 7/27/59	
PHYSICIAN'S NAME (Type) W. G. Hall, 615 W. Montgomery Ave., Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.	22b. DATE THEREOF 7-27-59	22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	22d. LOCATION (City, town, or county) (State) Meyersdale, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER
the certificate should be executed within 24 hours after death.
the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral
forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar
or removal.

VS. A15ME(5)
SM 9/55

necessary, please see
r. Page 4 should be
to burial, cremation,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Sarasota</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>5 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sarasota</u> 48 X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2944 Uppertown Tango Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Bonnett</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 59</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dent'st</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Albert Bonnett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Spathelf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1918</u>		17. INFORMANT (Wife) <u>Mrs. Delmond Bonnett</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u>4</u> Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-2-59	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08053

8099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Secane</u> <u>75 x - 3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN Ib <u>34 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1014 Rhodes Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>James</u> Last <u>Boyd, Jr. III</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24, 1958</u>	9. AGE (In years last birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Boyd, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Louise McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>771.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Idiopathic Hypoproteinemia</u> DUE TO (c) <u>Months</u> INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>59</u> , to <u>July 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>59</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>7-2-59</u> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <u>John A. Oates, Jr.</u>		M.D. <u>John A. Oates, M. D.</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Trans.</u>		22b. DATE THEREOF <u>6 July 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Charles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Darby Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

MEDICAL CERTIFICATION

2

1

9VVVVVVVVVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner, if filled in by the funeral director, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2003

PROMID

CONTINUED

<p>1. Name of deceased: <i>Robert J. Thompson</i></p>	
<p>2. Date of death: <i>July 22, 2003</i></p>	
<p>3. Place of death: <i>Home</i></p>	
<p>4. Age at death: <i>78</i></p>	
<p>5. Sex: <i>Male</i></p>	
<p>6. Race: <i>White</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>	
<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>	
<p>10. Signature of registrar: <i>[Signature]</i></p>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08054

8100 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Boyd's TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Simpson Nursing Home				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Purdum TOWN STREET ADDRESS Monrovia R.F.D.			
3. NAME OF DECEASED (Type or Print) (First) Basil (Middle) T. (Last) BROWN				4. DATE OF DEATH (Month) (Day) (Year) July 20 19 59			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 20 1871		9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Ma.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas G. Brown				14. MOTHER'S MAIDEN NAME Catherin Moxley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Delaney Brown Monrovia R.F.D.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Cerebro-Vascular Accident ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cardio Vascular Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						INTERVAL BETWEEN ONSET AND DEATH 4 1/8 hours 8 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 July 19 59 , to 20 July 19 59 , that I last saw the deceased alive on 20 July 19 59 and that death occurred at 4:45 P.M. from the causes and on the date stated above. SIGNATURE John M. Smith M.D. Barnesville, Md DATE SIGNED 20 July 59 ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 22		NAME OF CEMETERY OR CREMATORY Mountain View		LOCATION (city, town, or county) (State) Purdum Md.	
24. REC'D BY REGISTRAR DATE JUL 23 '59		REGISTRAR'S SIGNATURE Arthur S. Kneass		25. FUNERAL DIRECTOR'S SIGNATURE Walter W. Barber		ADDRESS Laytonsville, Md	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08055

Reg. Dist. No.

8063

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>—</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>					
c. LENGTH OF STAY IN 1b <u>6 1/2 days</u>				d. STREET ADDRESS <u>4117 5th ST. N.W.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin Donnelly Browne</u>				4. DATE OF DEATH Month Day Year <u>7 - 27 1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-72</u>			
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Ins. Agent</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edwin Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy D Guesberry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Thrombosis</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-operative from prostatectomy</u> 34 days DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>59</u> , to <u>July 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>59</u> , and that death occurred at <u>2:35 A.M.</u> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>909 Pershing Dr. Silver Spring</u>				DATE SIGNED <u>7/27</u>					
ACTUAL SIGNATURE <u>Arthur J. Willets</u> M.D.				PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>			

Source: U.S. Census Bureau, *Marriage, Divorce, Remarriage in the 1990s*, Washington, D.C., 1995.

8101 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Brown</u>				4. DATE OF DEATH Month Day Year <u>July 28 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5, 1931</u>	
9. AGE (In years, last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick layer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Albert Kenneth Brown</u>				14. MOTHER'S MAIDEN NAME <u>Susan Helen Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>3 yrs.</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE HEPATIC FAILURE</u> DUE TO (c) <u>ACUTE HEMORRHAGIC PANCREATITIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>48 HOURS</u> <u>3 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE ALCOHOLISM TOXEMIA - OLIGURIA SHOCK</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 27</u> , 19 <u>57</u> , to <u>July 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D.				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave Gaithersburg, MD.</u>			
DATE SIGNED <u>July 29, 1957</u>							
PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jul. 31 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>		22d. LOCATION (City, town, or county) (State) <u>Redland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Diagon - Barker, Laytonville, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlinda S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

STATE OF NEW YORK
CERTIFICATE OF DEATH

3101

X

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

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1911

1912

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1914

1915

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8102

CERTIFICATE OF DEATH

08057

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Rest Home 6810 Ga. Ave., Silver Spring, Md.		d. STREET ADDRESS 608 Blick Drive 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last BROWN		4. DATE OF DEATH Month July Day 11 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Palmer		14. MOTHER'S MAIDEN NAME Ellen Coulter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Herbert C. Brown--		Address 608 Blick Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 422.1 DUE TO CHRONIC MYOCARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 2, 1958 , to JULY 11, 1959 , that I last saw the deceased alive on JULY 11, 1959 , and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Nanney Dr. 7-11-59 DATE SIGNED ACTUAL SIGNATURE Henry M. Lowden M.D. Cheng Chao, M.D. PHYSICIAN'S NAME (Type) Henry M. Lowden			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR JUL 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8064

CERTIFICATE OF DEATH

18058

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>10804 E. Nolcrest Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Nathan</u> Last <u>Brownstein</u>				4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-16</u>	9. AGE (In years last birthday) yrs. <u>42</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Civil Service Comm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Phillip Brownstein</u>				14. MOTHER'S MAIDEN NAME <u>Freida Bronstein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW2 AF</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mural Thrombus</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO <u>Coronary Arteriosclerosis</u> (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>2-3 days</u> <u>? years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-20</u> , 1959, to <u>7-22</u> , 1959, that I last saw the deceased alive on <u>7-22</u> , 1959, and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A Hare</u>				ADDRESS (Street, city or town, state) <u>809 Davis Ave, T.P. Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>				DATE SIGNED <u>11</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Urbington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Urbington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. D. Dunsen</u>				ADDRESS <u>Sons 3501-14 St.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6244 7-20-59 et

8103

CERTIFICATE OF DEATH

Reg. Dist. No.

08059

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>California</u> b. COUNTY <u>Los Angeles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German Town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palasades</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		d. STREET ADDRESS <u>Street address unknown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Marylander Home of Rest</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>		4. DATE OF DEATH <u>July 4 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James C. Courts</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fraser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records - The Marylander - German Town, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/15, 1954</u> to <u>7/4, 1959</u> , that I last saw the deceased alive on <u>7/2, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kern</u> M.D. <u>Demassey, Md.</u>		DATE SIGNED <u>7/7/59</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Los Angeles California</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>316 E Diamond Ave Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
STATE OF MARYLAND

WILLIAM BOWMAN
MAY 1903

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME OF DECEASED		WILLIAM BOWMAN	
AGE		10	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		MAY 1903	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		DIPHTHERIA	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
DATE OF BIRTH		MAY 1903	
MARRIAGE		NONE	
OCCUPATION		NONE	
EDUCATION		NONE	
RELIGION		NONE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. BOWMAN	
SIGNATURE OF WITNESSES		J. H. BOWMAN	
SIGNATURE OF DECEASED		WILLIAM BOWMAN	
SIGNATURE OF REGISTRAR		J. H. BOWMAN	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08060

8104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 75 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 472 North Thomas Street							
3. NAME OF DECEASED (Type or print) First Steven Middle Anthony Last Buday				4. DATE OF DEATH Month July Day 2 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1957	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) California				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Buday				14. MOTHER'S MAIDEN NAME Lilia Jaramillo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Leukemia DUE TO (c) 12 Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 18, 1959 , to July 2, 1959 , that I last saw the deceased alive on July 2, 1959 , and that death occurred at 11:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Schwab, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7-2-59			
PHYSICIAN'S NAME (Type) Paul Schwab, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/59		22c. NAME OF CEMETERY OR CREMATORY Woodfield		22d. LOCATION (City, town, or county) (State) Galleville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Q. Hardisty, Galleville, Md				24a. REC'D BY REGISTRAR DATE JUL 10 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1925	
Place of Birth		Race		Marital Status		Occupation	
New York City		White		Married		Teacher	
Date of Death		Time of Death		Place of Death		Cause of Death	
Dec 15, 1970		10:30 AM		Home		Heart Disease	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone	
[Signature]		John Doe, M.D.		123 Main St.		555-1234	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's Phone	
[Signature]		Jane Smith, Coroner		456 Elm St.		555-5678	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Phone	
[Signature]		Dr. John Doe		789 Oak St.		555-9012	
Hospital's Signature		Hospital's Name		Hospital's Address		Hospital's Phone	
[Signature]		St. Mary's Hospital		1010 N. Broadway		555-3456	

8105

CERTIFICATE OF DEATH

Reg. Dist. No.

08061

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>21 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>Rt. 2, R7D.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Hubert</u> Last <u>Burdette</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 28, 1872</u>	9. AGE (In years lost birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Perry Burdette</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Beecraft</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Roger W. Burdette</u> Address <u>25710 Ridge Rd. Damascus, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart disease</u> DUE TO (c) <u>Arteriosclerosis generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 years</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip about 2 years ago, Cerebral vasc. acc. 1945</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19____, to <u>7/13/59</u> , 19____, that I last saw the deceased alive on <u>7/12/59</u> , 19____, and that death occurred at <u>11:13</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Meador</u> M.D.				ADDRESS (Street, city or town, state) <u>Main Street</u> DATE SIGNED <u>7/14/59</u>			
PHYSICIAN'S NAME (Type) <u>G.F. Meadors, M.D.</u>				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Claggettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrman</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8065 CERTIFICATE OF DEATH

Reg. Dist. No. 08062

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>10804 Jewett St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Elaine</u> Last <u>Burke</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-19-46</u>	
9. AGE (In years lost birthday) yrs. <u>13</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student - Md. School for the Blind</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Burke</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Saunders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>pt's chart</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis.</u> DUE TO (c) <u>Contracted kidneys, Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 5, 1959</u> to <u>July 3, 1959</u> that I last saw the deceased alive on <u>July 2, 1959</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Patrick C Jamison</u> M.D. <u>12020 Georgia</u>				ADDRESS (Street, city or town, state) <u>Wheaton, Md</u> DATE SIGNED <u>July 3, 1959</u>			
PHYSICIAN'S NAME (Type) <u>PATRICK C. JAMISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>							

2087 CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08063

8106

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	c. LENGTH OF STAY IN 1b 5 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3702 Husted Dr.		d. STREET ADDRESS 3702 Husted Dr.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Maria C Middle Burns Last		4. DATE OF DEATH Month July Day 2 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker of Quality		10b. KIND OF BUSINESS OR INDUSTRY Cards	11. BIRTHPLACE (State or foreign country) Joplin Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Mack	
14. MOTHER'S MAIDEN NAME Katherine Kleine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no	
16. SOCIAL SECURITY NO. 496-09-0332		17. INFORMANT Charles J. Burns Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion (c) Coronary occlusion DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/7/59	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JUL 7 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2101

Form with multiple sections for medical examination and death certification, including fields for patient information, cause of death, and examiner's signature.

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8107

CERTIFICATE OF DEATH

Reg. Dist. No.

08064

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Arthur Filmore Burriss</i>		4. DATE OF DEATH Month Day Year <i>July 25 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 8, 1886</i>
9. AGE (In years last birthday) <i>73</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>11</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Mont. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS Burriss</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>577-20-2641</i>	
17. INFORMANT <i>son-in-law</i> Address <i>Time as above</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial degeneration</i> DUE TO (c) <i>A.S.H.D.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchitis, Pul. Emphysema & C.H.F.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1, 1952</i> to <i>7/26, 1959</i> that I last saw the deceased alive on <i>7/26, 1959</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stephen N. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>Rockville, Md</i> DATE SIGNED <i>7/26/59</i>	
PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i>		<i>Rockville, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/29/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>AUG 28 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knaus</i>	

CERTIFICATE OF DEATH

2107

Wm. C. M. M.

1

1425-224

2-AM-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8066 CERTIFICATE OF DEATH

08065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park,			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS 7514 Carroll Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Byrde				4. DATE OF DEATH Month Day Year July 13, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1959	9. AGE (In years last birthday) yrs. 15	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Edward Louis Byrde				14. MOTHER'S MAIDEN NAME Anne Brewster Edwards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT father			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752X Congenital hydrocephalus, atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED O. B. Beardsley M.D. Washington Sanitarium and Hosp. 7/13/59							
ACTUAL SIGNATURE O. B. Beardsley M.D. Washington Sanitarium and Hosp. 7/13/59							
PHYSICIAN'S NAME (Type) O. B. Beardsley, M. D. Washington Sanitarium and Hospital, Takoma Park, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-14-59		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park, Maryland				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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JUL 16 '59

Arthur S. Kears

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8108
CERTIFICATE OF DEATH

08066
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 38 Anderson Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Christine Lynn CAMPANA				4. DATE OF DEATH Month Day Year July 1 19 59											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-59		9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months Days 13 49		IF UNDER 24 HRS. Hours Min. 13 49			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard Paul CAMPANA								14. MOTHER'S MAIDEN NAME Janet Arlene HELENSKI							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				INFORMANT Address (F) Richard P. Campana, same as #2 above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1 , 19 59 , to July 1 , 19 59 , that I last saw the deceased alive on July 1 , 19 59 , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda M.D. U. S. Naval Hospital 7-2-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) F. DE PAOLA, LCDR, MC, USN Bethesda, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				22b. DATE THEREOF 7-4-59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's				22d. LOCATION (City, town, or county) (State) Salem Mass.					
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey R.A. Humphrey Funeral Home, 7557 Wis. Ave., N.W. Bethesda, Md.								24a. REC'D BY REGISTRAR DATE JUL 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

2051212XV4

CERTIFICATE OF DEATH

2103

10

1. Name of deceased (Print name)
2. Sex
3. Date of birth
4. Place of birth
5. Usual residence
6. Cause of death
7. Date of death
8. Time of death
9. Signature of physician
10. Signature of registrar
11. Signature of informant
12. Name of informant
13. Address of informant
14. Date of completion of certificate
15. Registrar's office

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8109

CERTIFICATE OF DEATH

08067

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville,			
c. LENGTH OF STAY IN 1b 1 Hour				d. STREET ADDRESS 1021 Baltimore Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gregory Middle Alvin Last Carper			4. DATE OF DEATH Month July Day 14 Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1957		9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Alvin C. Carper				14. MOTHER'S MAIDEN NAME Virginia Conner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE 155.1 DUE TO SEVERE ANEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEPATIC CELL CARCINOMA-INFANTILE TYPE (c) G MOS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTASES TO THE LUNGS FROM (C) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29 , 19 59 , to July 13 , 19 59 , that I last saw the deceased alive on July 14 , 19 59 , and that death occurred at 4:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7-14-59 ACTUAL SIGNATURE Richard C. Mechanic M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Richard C. Mechanic, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/59		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) York, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUL 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Kraus			

Patient had been followed in Clinic.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992

1990-1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8110
CERTIFICATE OF DEATH

08068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 765 North 6th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle (None) Last Castellano				4. DATE OF DEATH Month July Day 19 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 7, 1908	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Sports Events Sports		10b. KIND OF BUSINESS OR INDUSTRY Sports	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Antonio Castellano		14. MOTHER'S MAIDEN NAME Letizia DeRogatis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 152-05-9287		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemic Shock DUE TO (b) Pneumonitis DUE TO (c) Rheumatic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 36 hours 4 Days 17 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Severe Mitral Stenosis with Thrombus Formation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 5 , 19 59 , to July 19 , 19 59 , that I last saw the deceased alive on July 19 , 19 59 , and that death occurred at 7:55a M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Lazar Greenfield, M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) LAZAR GREENFIELD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 7-20-59		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) N. Arlington, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE JUL 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

2529

8111

CERTIFICATE OF DEATH

08069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EMORY GROVE d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSE Middle LEE Last CHAMBERS		4. DATE OF DEATH Month JULY Day 28 Year 19 59					
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA			
13. FATHER'S NAME JOHN KINNEY		14. MOTHER'S MAIDEN NAME SALLIE ----		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JULY 24 , 19 59 , to JULY 28 , 19 59 , that I last saw the deceased alive on JULY 27 , 19 59 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-28-59							
ACTUAL SIGNATURE E. J. Broschart		M.D. E. J. Broschart, M. D.		PHYSICIAN'S NAME (Type) GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/59		22c. NAME OF CEMETERY OR CREMATORY Emory Grove..			
22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworde		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE AUG 5 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Knud			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonappers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8112

CERTIFICATE OF DEATH

Reg. Dist. No.

08070

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>FAIRFAX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herndon</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>143 Station St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Cedarcroft Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Dewey</u> Last <u>Chappell</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-99</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>MANASSAS, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Wallace F. Chappell</u>		14. MOTHER'S MAIDEN NAME <u>Kellie Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-05-0434</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15-59</u> , 19 <u>59</u> , to <u>7-15-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>59</u> , and that death occurred at <u>1:25 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Aldo Vacca</u>		M.D. <u>610 Kennebec Av. Tak Park 7-15-59</u>	
PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal-Burial July 18, 1959</u>	<u>July 18, 1959</u>	<u>National Memorial Park</u>	<u>Falls Church, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Berkley Green</u>		24. REC'D BY REGISTRAR <u>Arthur L. Huns</u>	
ADDRESS <u>Herndon, Va.</u>		DATE <u>JUL 20 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section B from the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8113

CERTIFICATE OF DEATH

08071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Leo</u> Last <u>Claggett</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24 - 1899</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm - Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles Claggett</u>		14. MOTHER'S M maiden NAME <u>Cora E. Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-03-9329</u>	
17. INFORMANT <u>Mrs Louise Thrift</u> Address <u>Clarksburg, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO <u>4 years</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>July 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>59</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon E. Martens</u>		ADDRESS (Street, city or town, state) <u>Sermantown, Md.</u> DATE SIGNED <u>7-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hellen, Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '59</u>	
ADDRESS <u>Barnesville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

STATE OF NEW YORK

County of ...

City of ...

State of New York

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1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Westmoreland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jennettsville 75X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4206 Round Hill Rd</u>			d. STREET ADDRESS <u>Kenn st Box 131</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Victoria Clark</u>			4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1901</u>		9. AGE (In years last birthday) <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Wilson Baker</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Wade</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Samuel H. Clark - Son</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Bur-Transit July 22, 59 East View Cemetery		Delmont, Penna.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Robert A. Pumphrey Bethesda, Maryland		DATE JUL 23 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
FIVE - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
HEALTH DISTRICT

MEDICAL EXAMINER

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO LOT

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CHAIR

DATE OF ENTRY INTO TABLE

DATE OF ENTRY INTO CUPBOARD

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO BATH

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO HALL

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARDEN

PROVIDED

DATE OF DEATH: JULY 25, 1915
PLACE OF DEATH: BALTIMORE, MARYLAND
CAUSE OF DEATH: ...
MANNER OF DEATH: ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8115

CERTIFICATE OF DEATH

Reg. Dist. No. 215

08073

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Abram Middle CLAUDE Last				4. DATE OF DEATH Month July Day 6 Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-81	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Washington CLAUDE				14. MOTHER'S MAIDEN NAME Fanny WILKINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myelocytic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 mo.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease, diabetes mellitus, acute septicemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June 23 , 19 59 , to July 6 , 19 59 , that I last saw the deceased alive on July 6 , 19 59 , and that death occurred at 9:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-6-59							
ACTUAL SIGNATURE <i>F. J. Linehan</i>		M.D. U. S. Naval Hospital		DATE SIGNED 7-6-59			
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR., LCDR, MC, USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7-7-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory	22d. LOCATION (City, town, or county) Suitland	(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawler's & Sons</i>		ADDRESS 1756 Pa. Ave., N.W., WDC		24a. REC'D BY REGISTRAR JUL 8 59	24b. REGISTRAR'S SIGNATURE <i>Archie L. Kraus</i>		

Page 4
24 hours after death.
The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, or by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, or by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06073

STATE OF TEXAS
COUNTY OF DALLAS

1111



Know all men by these presents, that

John A. Smith

(Name)

of the County of Dallas, State of Texas

do hereby certify that

the within and foregoing is a true and correct

copy

of the original thereof, as the same appears

from the records of the County of Dallas

State of Texas, this 11th day of

January, 1911

(Signature)

John A. Smith

(Signature)

County Clerk

(Signature)

Notary

Witness my hand and seal this 11th day of

January, 1911

John A. Smith

(Signature)

County Clerk

(Signature)

State of Texas

(Signature)

County of Dallas

(Signature)

John A. Smith

(Signature)

County Clerk

(Signature)

State of Texas

(Signature)

County of Dallas

(Signature)

John A. Smith

(Signature)

County Clerk

(Signature)

State of Texas

(Signature)

County of Dallas

(Signature)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
8116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY in 1b minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville & Boetler Rds.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 5228 North 11th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin Milton Clem		4. DATE OF DEATH July 10 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1938
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Mgr. Contractor		10b. KIND OF BUSINESS OR INDUSTRY Septic Installation	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles M. Clem		14. MOTHER'S MAIDEN NAME Evelyn Carper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. and Mrs. Evelyn R. Clem	
17. INFORMANT (Police Record)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 825X DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Injuries, extreme (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident	
20c. TIME OF INJURY Month, Day, Year 2:50 a.m. 7/10/59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) Silver Spring (County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 7/10/59	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) Fairfax Co. (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR JUL 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08075
8117										
CERTIFICATE OF DEATH										Reg. Dist. No. 215
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 4722 Hudson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CLOS Middle Last					4. DATE OF DEATH Month July Day 14 Year 19 59					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-59		9. AGE (In years last birthday) — yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY — — — — —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months — Days — Hours 1 Min. 7		
13. FATHER'S NAME David Leroy CLOS					14. MOTHER'S MAIDEN NAME Josephine Jacqueline KIEUZKEMPER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x DUE TO Pneumatury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr 7 min										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 14 , 19 59 , to July 14 , 19 59 , that I last saw the deceased alive on July 14 , 19 59 , and that death occurred at 7:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-14-59										
ACTUAL SIGNATURE H. A. Pearson					M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) H. A. PEARSON, LT, MC, USN					Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Ft. Snelling National		22d. LOCATION (City, town, or county) (State) Minneapolis Minnesota			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey R. A. Humphrey Funeral Home, Bethesda, Md.					24a. REC'D BY REGISTRAR JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

2051223XV1

U. S. Naval Hospital
1 m. 1
Baltimore
Maryland
U. S. A.

Josephine Augustine Kibben
Hospital Record

July 14 1952
July 14 1952

U. S. Naval Hospital
Baltimore, Md.
U. S. A.
Baltimore, Md.
U. S. A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08076

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7420 Maple Ave</u>			d. STREET ADDRESS <u>7420 Maple Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Allie Beel Coffman</u>			4. DATE OF DEATH Month Day Year <u>July 4 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1875</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>na</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>	
13. FATHER'S NAME <u>Frank M. Jenkins</u>			14. MOTHER'S MAIDEN NAME <u>Annie Dadismom</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>420.1</u>		17. INFORMANT <u>Lillian I. Rader</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease</u> DUE TO (c) <u>10 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschek</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JULY 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>LAGERS TOWN</u>		(State) <u>Md.</u>		22e. REC'D BY REGISTRAR <u>7-4-59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>		ADDRESS <u>254 Carroll St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **88077**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>DE.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 478-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairhill Nursing Home</u>				d. STREET ADDRESS <u>4441 Greenway Pkwy.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Woodlums</u> Last <u>Colpitts</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-20-68</u>	
9. AGE (in years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>For. Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ky.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm Woodlums</u>				14. MOTHER'S MAIDEN NAME <u>Cum St. Claire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nursing Home Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>		22b. DATE THEREOF <u>7/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lexington Cemetery.</u>		22d. LOCATION (City, town, or county) (State) <u>Lexington, Kentucky.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F Birch, s Sons 3034 M St. Wash. 7 D.C.</u>				24a. REC'D BY REGISTRAR <u>JUL 17 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE OF TEXAS
DEPARTMENT OF HEALTH - BATHHOUSE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is partially filled out with handwritten text.

Section 1: Patient Information
Name: [Handwritten Name]
Age: [Handwritten Age]
Sex: [Handwritten Sex]
Race: [Handwritten Race]
Occupation: [Handwritten Occupation]

Section 2: Cause of Death
Immediate Cause: [Handwritten Cause]
Underlying Cause: [Handwritten Cause]
Manner of Death: [Handwritten Manner]

Section 3: Examiner's Information
Examiner's Name: [Handwritten Name]
Examiner's Title: [Handwritten Title]
Signature: [Handwritten Signature]

Section 4: Additional Information
Date of Death: [Handwritten Date]
Place of Death: [Handwritten Place]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8118-

CERTIFICATE OF DEATH

Reg. Dist. No.

08078

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1905</u>		d. STREET ADDRESS <u>12500 Columbia Pike</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"GREEN RIDGE"</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARE Madeline Conley</u>		4. DATE OF DEATH <u>July 22 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1888</u>
9. AGE (In years last birthday) <u>71</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theophilus Jones Geary</u>		14. MOTHER'S MAIDEN NAME <u>Mary Goodson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>REGINALD G. CONLEY, FAIRLAND, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>4 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> , to <u>7/22/1959</u> , that I last saw the deceased alive on <u>July 17, 1959</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Sandy Spring, Maryland</u> DATE SIGNED _____ PHYSICIAN'S NAME (Type) <u>J. W. Bird, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episc. Ch. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Fairland, Montg. Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

250-50

<div style="display: flex; justify-content: space-between;"> Item 18 Film 246 812 59 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08080 </div> <div style="display: flex; justify-content: space-between;"> 8088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1218 Rockville Pike, Lot.13					d. STREET ADDRESS 1218 Rockville Pike Lot.13			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle Lee Last Crosby					4. DATE OF DEATH Month July Day 13 Year 1959				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/27/1914		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME XXXXXXXXXX James Lee McClnney					14. MOTHER'S MAIDEN NAME Martha L. Roundtree				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address James Crosby (husband) Item.2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 581.0 IMMEDIATE CAUSE (a) Fat embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty liver DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/14/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			22d. LOCATION (City, town, or county) (State) Suffolk, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.					24a. REC'D BY REGISTRAR DATE JUL 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8119

CERTIFICATE OF DEATH

Reg. Dist. No. **88079**

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10501 Parkwood Drive</i>		d. STREET ADDRESS <i>10501 Parkwood Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Ada E. Conner</i>		4. DATE OF DEATH <i>July 17 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/13/1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brook Farm Restaurant Wash. D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Crandell</i>		14. MOTHER'S MAIDEN NAME <i>Unobtainable</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>W.W.I.</i>		16. SOCIAL SECURITY NO. <i>220-34-3969</i>	
17. INFORMANT <i>Betty Conner Laverty</i>		Address <i>13025 Turkey Branch Pky. Rockville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinomatosis</i> DUE TO (c) <i>Carcinoma of stomach</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pernicious anemia</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>None</i> 19 <i>59</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/21</i> 19 <i>59</i> , to <i>7/17</i> 19 <i>59</i> , that I last saw the deceased alive on <i>7/17</i> 19 <i>59</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhan</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i> DATE SIGNED <i>7/17/59</i>	
PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAN Chevy Chase 15 Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/21/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Arlington, Virginia</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.-2901 14th St., N.W.</i>		24a. REC'D BY REGISTRAR <i>JUL 20 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>

CERTIFICATE OF DEATH

2313

40000

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		M		35		W		12/1/28		MOBILE, ALABAMA	
7. CITY OF DEATH		8. COUNTY		9. STATE		10. ZIP CODE		11. DATE OF DEATH		12. TIME OF DEATH	
BALTIMORE		BALTIMORE		MD		21201		4/4/68		10:15 AM	
13. CAUSE OF DEATH		14. MANNER OF DEATH		15. PLACE OF DEATH		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS	
CORONARY THROMBOSIS		NATURAL		HOME		[Signature]		[Signature]		[Signature]	
19. HISTORY OF ILLNESS		20. PREVIOUS ILLNESS		21. PREVIOUS SURGERY		22. PREVIOUS TRAUMA		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL	
HEART DISEASE		NONE		NONE		NONE		NONE		NONE	
25. OCCUPATION		26. EDUCATION		27. RELIGION		28. MARITAL STATUS		29. SOCIAL HISTORY		30. ADDITIONAL COMMENTS	
BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		SMOKES 10 CIGARETTES		NONE	

RECEIVED
BALTIMORE
MAY 1 1968
DEPARTMENT OF HEALTH

8120

CERTIFICATE OF DEATH

08081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>44.3 - Oakland Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Cooper Cross</u>		4. DATE OF DEATH Month Day Year <u>July 18 1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1902</u>
9. AGE (In years last birthday) <u>57</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ed Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Lear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Cross / Same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Uremia</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-16, 1959</u> to <u>7-18 1959</u> that I last saw the deceased alive on <u>7-17, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. G. Hall</u>		ADDRESS (Street, city or town, state) <u>618 W. Montgomery Ave Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>		DATE SIGNED <u>7/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park,</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

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8121

CERTIFICATE OF DEATH

08082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28314 Kemptown Rd.				d. STREET ADDRESS 28314 Kemptown Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Melanie Middle T. Last Deakyne				4. DATE OF DEATH Month July Day 2 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 25, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charleston, S.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sprague Simons				14. MOTHER'S MAIDEN NAME Marie Taueall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-28-1445		17. INFORMANT E.L. Dieudonne, Jr. Address 501 Sherbrook Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 5 mos years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Fracture of right hip, chronic bronchitis, emaciation.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 10, 19 59 to July 2, 19 59 , that I last saw the deceased alive on July 1, 19 59 , and that death occurred at 8:15 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED 7/4/59							
ACTUAL SIGNATURE G.F. Meadors M.D.				PHYSICIAN'S NAME (Type) G.F. Meadors, M.D. Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm L. Mohs ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR DATE JUL 7 59		24b. REGISTRAR'S SIGNATURE Arthur L. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08083

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John		c. LENGTH OF STAY IN 1b X Cabin John XXXXXX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		d. STREET ADDRESS Cabin John Gardens #3 Thorne Road	
3. NAME OF DECEASED (Type or print) First SANFORD Middle DeGroat III Last DeGroat III		4. DATE OF DEATH Month 7 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1943
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 10 Days 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Sanford DeGroat Jr.		14. MOTHER'S MAIDEN NAME Frances E. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sanford DeGroat Jr-Father-Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c) 929.8		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Drowned while swimming in Potomac River	
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 7/2/59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Nr. Cardarock Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUL 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. F...	

STATE
DEPARTMENT



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10003

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		10/15/1900	
Place of Birth		Baltimore, Md.	
Usual Residence		123 Main St., Baltimore, Md.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date		10/20/1945	
Place		Baltimore, Md.	
Signature of Coroner		[Signature]	
Date		10/20/1945	
Place		Baltimore, Md.	
Signature of Registrar		[Signature]	
Date		10/20/1945	
Place		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8089

CERTIFICATE OF DEATH

Reg. Dist. No.

08084

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 478-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MANOR SANITARIUM		d. STREET ADDRESS 3833 GARFIELD STREET, N.W.	
3. NAME OF DECEASED (Type or print) First SOLEMON Middle DESKIN Last DESKIN		4. DATE OF DEATH Month JULY 24, 1959 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER, 1880
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - GROCER		10b. KIND OF BUSINESS OR INDUSTRY RUSSIA	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORDECAI DESKIN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MARK DESKIN		Address 3833 GARFIELD ST., N.W., WASH., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Decompensation (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. , 1959, to July 22, 1959 , that I last saw the deceased alive on July 22, 1959 , and that death occurred at 5:20 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Isidore Shulman M.D. 9-5-1959		Wash. D.C.	
PHYSICIAN'S NAME (Type) ISIDORE SHULMAN		Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-26-59	
22c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE D. Sanzowsky & Sons		ADDRESS -3501-14th St. N.W.	
24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

88083

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

88083

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45 years"]</p>	
<p>4. DATE OF DEATH [Faint text, possibly "July 1, 1933"]</p>		<p>5. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>6. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart failure"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. ..."]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint text, possibly "J. H. ..."]</p>		<p>11. SIGNATURE OF WITNESS [Faint text, possibly "J. H. ..."]</p>		<p>12. SIGNATURE OF DECEASED [Faint text, possibly "J. H. ..."]</p>	

8123

CERTIFICATE OF DEATH

Reg. Dist. No.

08085

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Wheaton - Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>11702 Hatcher Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maggie</u> <u>DEW</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>20</u> <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Leona ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter Mrs Willa Belle Willis</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 ACUTE MYOCARDIAL INFARCT</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus 12 years duration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1959</u> to <u>July 20, 1959</u> that I last saw the deceased alive on <u>7/20</u> , 19 <u>59</u> , and that death occurred at <u>3 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Everett</u> M.D.		ADDRESS (Street, city or town, state) <u>9400 Conn. Ave</u> DATE SIGNED <u>7/20/59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E EVERETT Kensington Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Trans.</u>	22b. DATE THEREOF <u>7-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bailey Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bailey, North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 23 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

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CERTIFICATE OF DEATH

1900

First Name

Full Name

Home

Home

Home

Signature of Minister

Signature of Registrar

CERTIFICATE OF DEATH

Reg. Dist. No.

8124

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood (Rural)				c. LENGTH OF STAY IN 1b X Gaithersburg, (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Russells Nursing Home				e. STREET ADDRESS Goshen, Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle LEE Last DIGGS		4. DATE OF DEATH Month July Day 25 Year 19 59		5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1891		9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Diggs				14. MOTHER'S MAIDEN NAME Rebecca ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		INFORMANT Mrs. Hattie Woods. 133 Livingston Ave., Albany, N. Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Pulmonary Fibrosis (independent) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 19 58 , to July 25, 19 59 , that I last saw the deceased alive on July 25, 19 59 , and that death occurred at 45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Webster Sewell Silver Spring DATE SIGNED 7-27-59							
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Silver Spring					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/59		22c. NAME OF CEMETERY OR CREMATORY Brooke Grove.,		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

1

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, after the death of the deceased. The funeral director, after the death of the deceased, should be filled with the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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STATE OF NEW YORK

CERTIFICATE OF DEATH

2124

County of ...

City of ...

(Date)

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8125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck (Rural) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolsville, d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Frank Last Dorsey				4. DATE OF DEATH Month July Day 28 Year 1959			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1853	9. AGE (In years last birthday) 106 yrs.	IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Unknown				
14. MOTHER'S MAIDEN NAME Millie Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT Frank Dorsey, Rookville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thyroid Hypertrophy						INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month 7 Day 28 Year 1959 Hour a. m. p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from 8:11 , 19 59 to 7:28 , 19 59 that I last saw the deceased alive on 7:28 , 19 59 , and that death occurred at 9:30 A. M. from the causes and on the date stated above.				
ACTUAL SIGNATURE Webster Sewell			DATE SIGNED 7-29-59				
PHYSICIAN'S NAME (Type) WEBSTER SEWELL			ADDRESS (Street, city or town, state) Rt. 1 Silver Spring				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7/31/59		22c. NAME OF CEMETERY OR CREMATORY Jerusalem,		
22d. LOCATION (City, town, or county) (State) Poolsville, Md.			23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				
ADDRESS Rookville, Md.			24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of deceased

Date of death

Place of death

Cause of death

Manner of death

Age at death

Sex

Usual residence

Occupation

Name of physician

Name of medical examiner

Name of coroner

Name of registrar

Signature of physician

Signature of medical examiner

Signature of coroner

Signature of registrar

Signature of deceased

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

8126

CERTIFICATE OF DEATH

08088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Almonds Nursing Home</u>				d. STREET ADDRESS <u>7034 Strathmore Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Dukes</u> Last <u>Dukes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Cook</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Simpson</u>			14. MOTHER'S MAIDEN NAME <u>Susan Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>821 Gates Ave</u> <u>Mrs Pearl Palmer Brooklyn, N.Y.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Carcinoma</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } DUE TO (b) <u>Operated upon at Suburban Hospital</u> DUE TO (c) <u>3/8/59</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3/8/59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 22, 1959</u> to <u>July 2, 1959</u> , that I last saw the deceased alive on <u>July 1, 1959</u> , and that death occurred on <u>July 2, 1959</u> at <u>8A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Webster Sewell</u>			M.D. <u>Norbeck, Rtl Silver Spring</u>			DATE SIGNED <u>7/5/59</u>	
PHYSICIAN'S NAME (Type) <u>Webster Sewell</u>			ADDRESS (Street, city or town, state)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>			ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

10100

10000



8090

CERTIFICATE OF DEATH

08089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 5 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 922 Viers Mill Rd.		d. STREET ADDRESS 922 Viers Mill Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Duvall		4. DATE OF DEATH Month July Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Darby		14. MOTHER'S MAIDEN NAME Eliza Jane Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Darby Duvall		Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) A.S.H.D.			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 40 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholecystitis & Bronchitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/53 , to 7/16/59 , that I last saw the deceased alive on 7/16/59 , and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 7/16/59	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 18	22c. NAME OF CEMETERY OR CREMATORY Damascus	22d. LOCATION (City, town, or county) (State) Damascus Md.
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

05888

1038

Name of Deceased		John A. Jones	
Sex		Male	
Age		35 Years	
Date of Birth		1900	
Place of Birth		Boston, Mass.	
Cause of Death		Heart Disease	
Date of Death		1935	
Place of Death		Boston, Mass.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6246 7-31-59 et

8127

CERTIFICATE OF DEATH

Reg. Dist. No.

08090

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Partnership Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Wootton Elgin</u>		4. DATE OF DEATH <u>July 21 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaning & Dying</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes - U.S.A.</u>	
13. FATHER'S NAME <u>Charles F. Elgin</u>		14. MOTHER'S MAIDEN NAME <u>Helen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>109-18-7832</u>	
17. INFORMANT <u>Charles W. Elgin</u>		Address <u>Poolesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cerebral & Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1956</u> , to <u>21 July, 1959</u> , that I last saw the deceased alive on <u>21 July, 1956</u> , and that death occurred at <u>4:40 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Smith</u>		ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u> DATE SIGNED <u>22 July 59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Hilton</u>		ADDRESS <u>Barnesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>80A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp</u>			d. STREET ADDRESS <u>1215 Tanby Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Llewellyn Edward Elliott</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1909</u>		9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baterologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Guam</u>	
13. FATHER'S NAME <u>Hiram Elliott</u>			14. MOTHER'S MAIDEN NAME <u>Conchita Martinez</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-10-2817</u>		17. INFORMANT <u>M-C. police</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>56 Silver Spring</u>	
20f. (City or town) <u>56 Silver Spring</u>		20g. (County) <u>Montgomery</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-16-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEM</u>	
22d. LOCATION (City, town, or county) <u>BLADENSBURG MD</u>		22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		ADDRESS <u>3801 Cleveland Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hughes</u>					

FOR STATE
HEALTH DEPT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

SIGNATURE OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

00001

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
20002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. PREVIOUS ILLNESS

10. PRESENT ILLNESS

11. CAUSE OF DEATH

12. IMMEDIATE CAUSE

13. INTERMEDIATE CAUSE

14. UNDERLYING CAUSE

15. DATE OF EXAMINATION

16. PLACE OF EXAMINATION

17. NAME OF EXAMINER

18. SIGNATURE OF EXAMINER

8128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08092

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seymour Nursinghome</u>		d. STREET ADDRESS <u>724 Easley Street</u>	
3. NAME OF DECEASED (Type or print) <u>JEANNE</u> First <u>A</u> Middle <u>ERMERINS</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/76</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Paris, France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Langlois</u>		14. MOTHER'S MAIDEN NAME <u>Julie Marie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs. George E. Wendal, 724 Easley St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May, 1959</u> , to <u>7/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/10</u> , 19 <u>59</u> , and that death occurred on <u>7/18</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u>		ADDRESS (Street, city or town, state) <u>918 Univ. Blvd. E. Silver Spring, Md.</u> DATE SIGNED <u>7/18/59</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>7/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Biskis</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000000

CERTIFICATE OF DEATH

712

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. DATE OF DEATH</p>		<p>17. TIME OF DEATH</p>		<p>18. PLACE OF DEATH</p>		<p>19. PLACE OF BURIAL</p>		<p>20. PLACE OF INTERMENT</p>	
<p>21. NAME OF BURIAL PLACE</p>		<p>22. NAME OF INTERMENT PLACE</p>		<p>23. NAME OF BURIAL PLACE</p>		<p>24. NAME OF INTERMENT PLACE</p>		<p>25. NAME OF BURIAL PLACE</p>	
<p>26. NAME OF INTERMENT PLACE</p>		<p>27. NAME OF BURIAL PLACE</p>		<p>28. NAME OF INTERMENT PLACE</p>		<p>29. NAME OF BURIAL PLACE</p>		<p>30. NAME OF INTERMENT PLACE</p>	
<p>31. NAME OF BURIAL PLACE</p>		<p>32. NAME OF INTERMENT PLACE</p>		<p>33. NAME OF BURIAL PLACE</p>		<p>34. NAME OF INTERMENT PLACE</p>		<p>35. NAME OF BURIAL PLACE</p>	
<p>36. NAME OF INTERMENT PLACE</p>		<p>37. NAME OF BURIAL PLACE</p>		<p>38. NAME OF INTERMENT PLACE</p>		<p>39. NAME OF BURIAL PLACE</p>		<p>40. NAME OF INTERMENT PLACE</p>	
<p>41. NAME OF BURIAL PLACE</p>		<p>42. NAME OF INTERMENT PLACE</p>		<p>43. NAME OF BURIAL PLACE</p>		<p>44. NAME OF INTERMENT PLACE</p>		<p>45. NAME OF BURIAL PLACE</p>	
<p>46. NAME OF INTERMENT PLACE</p>		<p>47. NAME OF BURIAL PLACE</p>		<p>48. NAME OF INTERMENT PLACE</p>		<p>49. NAME OF BURIAL PLACE</p>		<p>50. NAME OF INTERMENT PLACE</p>	
<p>51. NAME OF BURIAL PLACE</p>		<p>52. NAME OF INTERMENT PLACE</p>		<p>53. NAME OF BURIAL PLACE</p>		<p>54. NAME OF INTERMENT PLACE</p>		<p>55. NAME OF BURIAL PLACE</p>	
<p>56. NAME OF INTERMENT PLACE</p>		<p>57. NAME OF BURIAL PLACE</p>		<p>58. NAME OF INTERMENT PLACE</p>		<p>59. NAME OF BURIAL PLACE</p>		<p>60. NAME OF INTERMENT PLACE</p>	
<p>61. NAME OF BURIAL PLACE</p>		<p>62. NAME OF INTERMENT PLACE</p>		<p>63. NAME OF BURIAL PLACE</p>		<p>64. NAME OF INTERMENT PLACE</p>		<p>65. NAME OF BURIAL PLACE</p>	
<p>66. NAME OF INTERMENT PLACE</p>		<p>67. NAME OF BURIAL PLACE</p>		<p>68. NAME OF INTERMENT PLACE</p>		<p>69. NAME OF BURIAL PLACE</p>		<p>70. NAME OF INTERMENT PLACE</p>	
<p>71. NAME OF BURIAL PLACE</p>		<p>72. NAME OF INTERMENT PLACE</p>		<p>73. NAME OF BURIAL PLACE</p>		<p>74. NAME OF INTERMENT PLACE</p>		<p>75. NAME OF BURIAL PLACE</p>	
<p>76. NAME OF INTERMENT PLACE</p>		<p>77. NAME OF BURIAL PLACE</p>		<p>78. NAME OF INTERMENT PLACE</p>		<p>79. NAME OF BURIAL PLACE</p>		<p>80. NAME OF INTERMENT PLACE</p>	
<p>81. NAME OF BURIAL PLACE</p>		<p>82. NAME OF INTERMENT PLACE</p>		<p>83. NAME OF BURIAL PLACE</p>		<p>84. NAME OF INTERMENT PLACE</p>		<p>85. NAME OF BURIAL PLACE</p>	
<p>86. NAME OF INTERMENT PLACE</p>		<p>87. NAME OF BURIAL PLACE</p>		<p>88. NAME OF INTERMENT PLACE</p>		<p>89. NAME OF BURIAL PLACE</p>		<p>90. NAME OF INTERMENT PLACE</p>	
<p>91. NAME OF BURIAL PLACE</p>		<p>92. NAME OF INTERMENT PLACE</p>		<p>93. NAME OF BURIAL PLACE</p>		<p>94. NAME OF INTERMENT PLACE</p>		<p>95. NAME OF BURIAL PLACE</p>	
<p>96. NAME OF INTERMENT PLACE</p>		<p>97. NAME OF BURIAL PLACE</p>		<p>98. NAME OF INTERMENT PLACE</p>		<p>99. NAME OF BURIAL PLACE</p>		<p>100. NAME OF INTERMENT PLACE</p>	

RECEIVED BY JARVIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8070

CERTIFICATE OF DEATH

08093

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>29 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>110404 Huntley Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Madeline Davis</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SECRETARY to Pa. Senator</u>	
13. FATHER'S NAME <u>Henry Davis</u>		14. MOTHER'S MAIDEN NAME <u>Ida Christ Criste</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>075-18-0636</u>	
17. INFORMANT <u>Mr. Gabriel Ferazzi - same as above</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca of Breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		ADDRESS (Street, city or town, state) <u>217 University Blvd E</u>
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		DATE SIGNED <u>7-18-59</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. ALOYSIUS CEMETERY</u>
22d. LOCATION (City, town, or county) <u>CRESSON</u>		(State) <u>PENNA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

100000

DATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES	

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
8129
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08094
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MARYLAND Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 21 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2408 N. Capitol St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FORTUNE		4. DATE OF DEATH Month Day Year July 1 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-59
9. AGE (In years lost birthday) yrs. 21		10. AGE (In years lost birthday) yrs. 21	11. AGE (In years lost birthday) yrs. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reginald Elsworth FORTUNE		14. MOTHER'S MAIDEN NAME Gloria Jean WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity & immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 59 , to July 1 , 19 59 , that I last saw the deceased alive on July 1 , 19 59 , and that death occurred at 11:15 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-2-59 ACTUAL SIGNATURE F. De Paola M.D. PHYSICIAN'S NAME (Type) F. DE PAOLA. LCDR, MC, USN Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-6-59	
22c. NAME OF CEMETERY OR CREMATORY District of Columbia Morgue		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis		24a. REC'D BY REGISTRAR JUL 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

2051193XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8071 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08095

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery XXXXX XXXXX MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 3 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fair Hill Nursing Home 207 Hudson Ave.		e. STREET ADDRESS 4501 Conn. Ave., N.W.	
3. NAME OF DECEASED (Type or print) Anna First Middle Last		4. DATE OF DEATH July 27, 1959 Month Day Year	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wis.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Erdman		14. MOTHER'S MAIDEN NAME Anns ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Norsing Home Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN POSTMORTEM AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF July 29-59	
22c. NAME OF CEMETERY OR CREMATORY Wanderers Rest		22d. LOCATION (City, town, or county) (State) Milwaukee, Wisc.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Katter		24a. REC'D BY REGISTRAR DATE JUL 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Katter		DATE SIGNED 7/27/59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8130

CERTIFICATE OF DEATH

Reg. Dist. No. 08096

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Mary</u> Last <u>Gauntlett</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 13, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>25</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>GREAT BRITAIN</u>	
13. FATHER'S NAME <u>Charles Gauntlett</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Bailey Gauntlett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. John Francis</u>		Address <u>5441 - Nebraska Ave. N.W. Wash, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general & cerebral</u> (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>13 wks.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>46</u> to <u>7-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-7</u> , 19 <u>59</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Wildman</u>		M.D. <u>Wash, D.C.</u> ADDRESS (Street, city or town, state) <u>3729 Morrison St. Wash, D.C.</u> DATE SIGNED <u>July 8, 1959</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS A. WILDMAN</u>		<u>3729-MORRISON ST. WASH. D.C.</u>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson Co.</u>		ADDRESS <u>1300 - N ST. N.W. WASHINGTON, DC</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

CERTIFICATE OF DEATH

6-10-1941

NAME OF DECEASED		DATE OF DEATH	
MAYOR GEORGE W. ...		JUNE 10, 1941	
AGE		SEX	
...		...	
PLACE OF BIRTH		DATE OF BIRTH	
...		...	
OCCUPATION		EDUCATION	
...		...	
MARITAL STATUS		CAUSE OF DEATH	
...		...	
PLACE OF DEATH		DATE OF DEATH	
...		...	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
...		...	
DATE OF SIGNATURE		DATE OF SIGNATURE	
...		...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

1

8131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08097

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1/2 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26 d. STREET ADDRESS 716 Marshall Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Fred Gerald GILLESBY				4. DATE OF DEATH Month Day Year July 10 19 59											
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-16		9. AGE (In years last birthday) yrs. 43		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Air Force				10b. KIND OF BUSINESS OR INDUSTRY Armed Services				11. BIRTHPLACE (State or foreign country) Idaho				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert GILLESBY						14. MOTHER'S MAIDEN NAME Orpha SCHINDLER									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1941 to DOD				16. SOCIAL SECURITY NO. INFORMANT (W) Mrs. Pearl Gillesby, same as #2 above				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Infarction, myocardium DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 10 , 19 59 , to July 10 , 19 59 , that I last saw the deceased alive on July 10 , 19 59 , and that death occurred at 11:04 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 7-10-59															
ACTUAL SIGNATURE F. J. LINEHAN, JR., LCDR, MC, USN				M.D. U. S. Naval Hospital				7-10-59							
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR., LCDR, MC, USN				Bethesda 14, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-14-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home						ADDRESS 816 H St., NE, Wash. DC		24a. REC'D BY REGISTRAR DATE JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8072

CERTIFICATE OF DEATH

08098

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>2 days 8 3/4 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>	d. STREET ADDRESS <u>5401 9th St N.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Janny</u> Last <u>Gordon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-88</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>IS Rael Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Iida Shaeffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Patient's Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Auto</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertensive + Coronary Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>long duration</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>45</u> , to <u>July 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>59</u> , and that death occurred at <u>8:41</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D.		ADDRESS (Street, city or town, state) <u>7733 Alaska Ave N.W. Washington D.C.</u> DATE SIGNED <u>7/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 26, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>W. HYATTSVILLE Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis</u> ADDRESS <u>3501-14th St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

8073

CERTIFICATE OF DEATH

08099

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		d. STREET ADDRESS 3507 RAYMOOR ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle BELL Last GRANDSTAFF		4. DATE OF DEATH Month JULY Day 29 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/08
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vernon Crisman		14. MOTHER'S MAIDEN NAME Bertha B. Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 525-42-7288	
17. INFORMANT Mr. James O. Grandstaff, 3507 Raymoor Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized melanosis involving (c) lung, liver, skin, spine		Kensington, Md. BETWEEN ONSET AND DEATH 3 days 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) (State)	
21. I certify that I attended the deceased from Jan. 1958 , to 28 July, 1959 , that I last saw the deceased alive on 28 July, 1959 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Rd., Silver Spring, Md. DATE SIGNED 7/29/59			
ACTUAL SIGNATURE Ernest E. Harmon M.D.			
PHYSICIAN'S NAME (Type) ERNEST E. HARMON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/31/59	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zucka		24a. REC'D BY REGISTRAR DATE JUL 31 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed not less than 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8132

CERTIFICATE OF DEATH

Reg. Dist. No. 08100

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood c. LENGTH OF STAY IN 1b 16x-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Russell's Nurse Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 16x-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle GRIFFIN Last GRIFFIN		4. DATE OF DEATH Month July Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Griffin		14. MOTHER'S MAIDEN NAME Susie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary T. Conway		Address War Chapel Rd., Odenton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia DUE TO Cardiorenal Hypertension (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			INTERVAL BETWEEN ONSET AND DEATH 6 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 7/23/59 to 7/27/59 , 19____, that I last saw the deceased alive on 7/26/59 , 19____, and that death occurred at 1:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7.28.59			
ACTUAL SIGNATURE Webster Sewell M.D.		DATE SIGNED 7.28.59	
PHYSICIAN'S NAME (Type) Webster Sewell		at. 1 silver Spring	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/59	22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery,	22d. LOCATION (City, town, or county) (State) Bowie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swindler		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR AUG 5 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2182

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York		New York		Heart Disease		New York		10:00 AM		Natural		J. Smith		A. Jones	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Medical History		Postmortem Exam		Burial Place		Burial Date		Burial Time		Burial Place	
Teacher		Married		White		Catholic		High School		None		None		None		Catholic Cemetery		Jan 15, 1945		10:00 AM		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Death Cert. Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
J. Smith		A. Jones		B. Brown		C. Green		D. White		E. Black		F. Grey		G. Blue		H. Yellow		I. Purple		J. Pink		K. Red	

8133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>#5 Chinguapin Village</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edgar</u> Last <u>Grover</u>			4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1939</u>	9. AGE (In years last birthday) <u>20 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John P. Grover</u>			14. MOTHER'S MAIDEN NAME <u>Edna Rasnick</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>223-50-6875</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postoperative Hemorrhage</u> DUE TO (b) <u>Coarctation of the aorta</u> DUE TO (c) <u>Rheumatic valvular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>July 5</u> , 1959, to <u>July 7</u> , 1959, that I last saw the deceased alive on <u>July 7</u> , 1959, and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>7-8-59</u> DATE <u>JUL 10 '59</u>							
ACTUAL SIGNATURE <u>E. Kent Carney, M.D.</u>			PHYSICIAN'S NAME (Type) <u>E. Kent Carney, M. D.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10 JULY 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL</u>		22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hall</u>			ADDRESS <u>CUNNINGHAM FUNERAL HOME</u> <u>CAMERON & ALFRED ST. ALEX. VA.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Thayer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
8134 Item 2 Film G246 7-31-59 et														
CERTIFICATE OF DEATH														
Reg. Dist. No. 08102														
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN lb 26 hrs									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban					d. STREET ADDRESS 5816 MacArthur Blvd. (Masonic & Eastern Star) 6000 N. E. Ave N. E. Home									
3. NAME OF DECEASED (Type or print) First William Middle H. Last Hailer Jr.					4. DATE OF DEATH Month July Day 22 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/85		9. AGE (In years lost birthday) yrs. 73						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bartender		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Wm. H. Hailer, Sr.					14. MOTHER'S MAIDEN NAME unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. unobtainable					INFORMANT Mrs. Grace Hailer-5816 MacArthur Blvd. Address Washington, DC				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 540.0 IMMEDIATE CAUSE (a) Subacute Gastric Hemorrhage DUE TO Chronic Peptic Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH 4 days 3+ yrs.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 15 Feb 1957 to 22 July 59 , that I last saw the deceased alive on 22 July 1959 and that death occurred at 2 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 Western Ave 22 July DATE SIGNED ACTUAL SIGNATURE A. H. Richwine M.D. chry chow 15, md. 1959 PHYSICIAN'S NAME A. H. RICHWINE														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7/24/59		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery Washington, D. C.		22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.					24a. REC'D BY REGISTRAR Jul 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

WILLIAM H. HALL

PAID

RECEIVED

U. S. DEPARTMENT OF THE ARMY

WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

8135

CERTIFICATE OF DEATH

Reg. Dist. No. 08103

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mississippi</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jackson</u> <u>61X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>128 Columbia Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ijmas</u> Middle <u>Q</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 4, 1899</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN NEELY QUINN</u>	
14. MOTHER'S MAIDEN NAME <u>REBECCA E. BURGESS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <u>NELL HARGRAVE</u> Address <u>4811 CHEVYCHASE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>18 hours</u> (c) <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 30, 1957</u> , to <u>July 1, 1959</u> that I last saw the deceased alive on <u>June 30, 1959</u> , and that death occurred at <u>12:53 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifton R. Pruett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4325 49th St. N.W. Wash. D.C. 7/1/59</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/3/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Walnut Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Walnut, Mississippi</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Bricker Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

1

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2610

8136

CERTIFICATE OF DEATH

08104

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lowell Middle Cosby Last HALL				4. DATE OF DEATH Month July Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-56	
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.		11. IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.		12. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (State or foreign country) Rhode Island				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frank Cosby HALL				14. MOTHER'S MAIDEN NAME Floreet WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) Frank C. Hall, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST (POST-OPERATIVE STATE) 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CONGENITAL HEART DISEASE DUE TO (c) (TRANSPOSITION OF GREAT VESSELS)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 29 , 19 59 , to July 8 , 19 59 , that I last saw the deceased alive on July 8 , 19 59 , and that death occurred at 7:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Douglas R. KOTH M.D.				U. S. Naval Hospital 7-9-59			
PHYSICIAN'S NAME (Type) Douglas R. KOTH, LT, MC, USN				Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial-Shipment				7-10-59			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
Rabun Creek Baptist Church				Gray Court So. Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest A. Adams ADDRESS				24a. REC'D BY REGISTRAR			
Adams Funeral Home, 4748 Wisc. Ave. NW, Wash. DC				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			
DATE JUL 10 '59							

1

24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8137
CERTIFICATE OF DEATH

08105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Abbeville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 33 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Honea Path 77X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 13 Sanders Street			
3. NAME OF DECEASED (Type or print) First Daisy Middle Ruth Last Hanley				4. DATE OF DEATH Month July Day 27 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1927		9. AGE (In years last birthday) yrs. 32	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		10b. KIND OF BUSINESS OR INDUSTRY Textile industry		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Ashley				14. MOTHER'S MAIDEN NAME Lillie Posey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cystitis with septicemia 289.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute intermittent porphyria DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24 , 19 59 , to July 27 , 19 59 , that I last saw the deceased alive on July 27 , 19 59 , and that death occurred at 2:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 7/27/59 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Paul H. Altrocchi M.D.				PHYSICIAN'S NAME (Type) Paul H. Altrocchi, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 7-30-59		22c. NAME OF CEMETERY OR CREMATORY Keowee Cemetery		22d. LOCATION (City, town, or county) (State) Abbeville Co., S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8138

CERTIFICATE OF DEATH

Reg. Dist. No. 08106

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resnor Nursing Home			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9303 Jesup Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ralph A. Hanson			4. DATE OF DEATH Month July Day 19 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1890	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 1 Days 4 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maritime		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Hanson		
14. MOTHER'S MAIDEN NAME Elise Swensen			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -		
16. SOCIAL SECURITY NO. Yes			INFORMANT Helen White - Item #2 - Sister		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 4 hours 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Achondroplasia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Brooklyn, New York		20g. (County) Brooklyn		20h. (State) New York	
21. I certify that I attended the deceased from August 3, 19 57 , to July 19, 19 59 , that I last saw the deceased alive on July 15, 19 59 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert G. Angle		DATE SIGNED 5009 Del Ray Ave., Bethesda, Md. 7/24/59			
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		5009 Del Ray Ave., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 7-22-59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
22d. LOCATION (City, town, or county) Brooklyn, New York		22e. (State) New York		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8133

CERTIFICATE OF DEATH

08107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Guilford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>1012 Ferndale Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>Bert</u> Last <u>Hart</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> , Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flex-O-Lators, Inc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James L. Hart</u>		14. MOTHER'S MAIDEN NAME <u>Pearl White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>450-24-8326</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>Mitral and Aortic Valvular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>20 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>59</u> , to <u>July 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>59</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C. Brockenbrough, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>	
PHYSICIAN'S NAME (Type) <u>Edwin C. Brockenbrough, M.D.</u>		DATE SIGNED <u>7/21/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 7/25/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carthage, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

8140

CERTIFICATE OF DEATH

Reg. Dist. No.

08108

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		d. STREET ADDRESS 107 SCOTT PLACE	
3. NAME OF DECEASED (Type or print) MARY ELIZABETH HATZES Last First Middle		4. DATE OF DEATH Month 7 Day 9 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 15 / 59
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GEORGE A JR.		14. MOTHER'S MAIDEN NAME JUSTINE SMILEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Intracranial Hemorrhages (c) Precipitous delivery with trauma		INTERVAL BETWEEN ONSET AND DEATH 1 Day 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-5 , 19 59 , to 7-9 , 19 59 , that I last saw the deceased alive on 7-9 , 19 59 , and that death occurred at 6:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jed W. Pedlow M.D.		ADDRESS (Street, city or town, state) 4700 BRADLEY BLVD DATE SIGNED 7-9-59	
PHYSICIAN'S NAME (Type) CHEVY CHASE 15, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/13/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawrence Sons Inc. ADDRESS 1756 Pa Ave. N.W. Wash. D.C.		24. REC'D BY REGISTRAR J 25. REGISTRAR'S SIGNATURE C. L. & Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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80124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Virginia</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>15 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Beverly</u> Middle <u>Gay</u> Last <u>Hayes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Edward Hayes Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Virginia Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>919.0</u>		17. INFORMANT <u>Father Paul E. Hayes Jr.</u> Address <u>- Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun shot .22 cal. pellets in brain</u> DUE TO (c) <u>24 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Children apparently playing with .22 cal rifle</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:35</u> P. M. <u>7-12-59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Darksville W. Va</u> 20f. (City or town) (County) (State) <u>Berkeley Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tuscarora Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Berkeley County W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>				ADDRESS <u>Martinsburg W. Va</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

MEDICAL CERTIFICATION

88

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8142

CERTIFICATE OF DEATH

Reg. Dist. No.

08110

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W. Henderson</u> Last <u>Henderson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR <u>71</u> Months <u>3</u> Days <u>27</u> Hours <u>27</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Vidia Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>	
INFORMANT <u>Lavinia Henderson</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiogenic carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1959</u> , to <u>July 14, 1959</u> , that I last saw the deceased alive on <u>July 14, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md</u> DATE SIGNED <u>7/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell, Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 17 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanes</u>	

01110

CERTIFICATE OF DEATH

2143

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

Stephen D. Crowell, Rockville, Maryland

Rockville Cemetery, Rockville, Maryland

Robert A. Pugh, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8074

CERTIFICATE OF DEATH

Reg. Dist. No. 08111

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAINT. & HOSPITAL</u>		d. STREET ADDRESS <u>3543 HERFORD PL., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>AUGUSTA</u> Middle <u>(NM)</u> Last <u>HERMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1887</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Feinberg</u>		14. MOTHER'S MAIDEN NAME <u>HANNA Abel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular disease</u> DUE TO (c) <u>Parkinson's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1947</u> to <u>July 4, 1959</u> , that I last saw the deceased alive on <u>July 4, 1959</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Orleans</u>		ADDRESS (Street, city or town, state) <u>9500 Colver Rd Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 6 - 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langinsky & Sons</u>		ADDRESS <u>2501-14th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hunt</u>	

CERTIFICATE OF DEATH

2074

111-0

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1900"]		TIME OF BIRTH [Faint text, possibly "10:30 AM"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "Dec 10, 1945"]		TIME OF DEATH [Faint text, possibly "8:00 PM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF BURIAL OFFICIAL [Faint signature]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8143

CERTIFICATE OF DEATH

Reg. Dist. No.

08112

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb since 6/23/59 17 To TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens SAN.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNA I. Middle Hewitt Last Hewitt		4. DATE OF DEATH Month 7 Day 10 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY Fields		14. MOTHER'S MAIDEN NAME MARY L. ZYPRECHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. JOSEPH A. CLARK, 22 Darwin Ave., Takoma Park,		Address (Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson Disease		INTERVAL BETWEEN ONSET AND DEATH 2 mo. 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1959 , to July 10, 1959 , that I last saw the deceased alive on July 9, 1959 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. R. Raedy M.D. 3701 Cedar St. Ch. Ch. Md. July 10, 1959 PHYSICIAN'S NAME (Type) J. R. Raedy M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 13, 1959	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. 8434 Georgia Ave., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1913

1913

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

MINNA I. ANNIN

June 20, 1913

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

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St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8075

CERTIFICATE OF DEATH

08113

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>10 hrs.</u>				d. STREET ADDRESS <u>1310 Merrimac Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Emma</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-80</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u>			
13. FATHER'S NAME <u>Jacob Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of brain</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>Primary Bronchogenic Carcinoma</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>59</u> , to <u>July 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>59</u> , and that death occurred at <u>5:10</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7105 Rigg Rd.</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Robert B. Ireay</u> M.D. <u>—</u>							
PHYSICIAN'S NAME (Type) <u>Robert B. Ireay</u> <u>Hyattsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>TRENTON N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. DeVol</u> ADDRESS <u>2224 Wis Ave. NW.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-113

CERTIFICATE OF DEATH

1907

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES M. HARRIS		JANUARY 1, 1907		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
45		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH RACE	
JANUARY 1, 1862		BALTIMORE, MARYLAND		White	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION	
JAMES M. HARRIS		MARY M. HARRIS		None	
FATHER'S BIRTH DATE		FATHER'S BIRTH PLACE		FATHER'S BIRTH RACE	
JANUARY 1, 1830		BALTIMORE, MARYLAND		White	
MOTHER'S BIRTH DATE		MOTHER'S BIRTH PLACE		MOTHER'S BIRTH RACE	
JANUARY 1, 1835		BALTIMORE, MARYLAND		White	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
Heart Disease		Natural		Dr. J. M. Harris	
DETAILS OF DISEASE		DETAILS OF EXAMINATION		SIGNATURE OF DECEASED	
Heart Disease		None		None	
DETAILS OF HISTORY		DETAILS OF PHYSICAL EXAMINATION		DETAILS OF MENTAL EXAMINATION	
None		None		None	
DETAILS OF TREATMENT		DETAILS OF POST-MORTEM EXAMINATION		DETAILS OF BURIAL	
None		None		None	
DETAILS OF FUNERAL		DETAILS OF INTERMENT		DETAILS OF CREMATION	
None		None		None	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF RECORDING AND STATISTICS ONLY. IT IS NOT A LEGAL DOCUMENT. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED HEREON.

8144

CERTIFICATE OF DEATH

Reg. Dist. No. 08115

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Diney</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 5 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>				d. STREET ADDRESS <u>17105 45th St</u>			
3. NAME OF DECEASED (Type or print) <u>Walter W. Hummer</u>				4. DATE OF DEATH <u>July - 26 - 19 59</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 - 1897</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Walpins-Rogers Milling Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Herndon Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Braeden Ezra Hummer</u>				14. MOTHER'S MAIDEN NAME <u>Laura Whaley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes?</u>		17. INFORMANT <u>Helen H. Schaefer</u> Address <u>203 Shirley St Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstital Nephritis</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Arterio-sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>14 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 21, 1957</u> to <u>July 26, 1959</u> , that I last saw the deceased alive on <u>7/24, 1959</u> , and that death occurred at <u>135 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u>			
DATE SIGNED <u>7/27/59</u>							
PHYSICIAN'S NAME (Type) <u>Dr. J. W. Bird</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8076

CERTIFICATE OF DEATH

Reg. Dist. No.

08114

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedar Haven Nursing Home</i>		d. STREET ADDRESS <i>17200 Holly Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>ADELAIDE</i> Last <i>HUMPHREY</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4, 1880</i>
9. AGE (In years, last birthday) <i>79</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker - Church School</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.G.</i>	
13. FATHER'S NAME <i>Waddie D. Lynham</i>		14. MOTHER'S MAIDEN NAME <i>Mary Evelyn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give date or dates of service)		16. SOCIAL SECURITY NO. <i>Ms. Adelaide H. Fraser, (same as #2)</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heat stroke</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 11, 1959</i> to <i>July 1, 1959</i> , that I last saw the deceased alive on <i>July 1, 1959</i> , and that death occurred at <i>8:15 AM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. B. Little</i>		ADDRESS (Street, city or town, state) <i>6911 5th St N.W., July 1, 1959</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>A. B. LITTLE, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 3, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24a. REC'D BY REGISTRAR <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

00114

DECEASED NAME LAST FIRST MIDDLE (Print or Write)		SEX MALE FEMALE	
AGE YEARS MONTHS DAYS (Print or Write)		DATE OF BIRTH YEAR MONTH DAY (Print or Write)	
PLACE OF BIRTH (Print or Write)		PLACE OF DEATH (Print or Write)	
OCCUPATION (Print or Write)		CAUSE OF DEATH (Print or Write)	
MANNER OF DEATH (Print or Write)		MEDICAL ATTENDANT (Print or Write)	
SIGNATURE OF DECEASED (Print or Write)		SIGNATURE OF MEDICAL ATTENDANT (Print or Write)	
SIGNATURE OF NEXT OF KIN (Print or Write)		SIGNATURE OF REGISTRAR (Print or Write)	
SIGNATURE OF CLERK (Print or Write)		SIGNATURE OF JUDGE (Print or Write)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G245, 7/24/59 fcy

8145

CERTIFICATE OF DEATH

08116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>10 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9905 Forest Grove Dr. Silver Spring, Md.</u>		d. STREET ADDRESS <u>19905 FOREST GROVE DR.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>—</u> Last <u>HYDER</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HOLMAN</u>		14. MOTHER'S MAIDEN NAME <u>EMMY WATTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>WILLIAM R. HYDER (SON)</u>		Address <u>9905 FOREST GROVE DR. SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF GALLBLADDER WITH METASTASIS</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>APPROX 5 WEEKS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 8</u> , 19 <u>59</u> , to <u>JULY 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JULY 13</u> , 19 <u>59</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. David Cooper</u>		ADDRESS (Street, city or town, state) <u>1732 J ST NW WASH DC</u> DATE SIGNED <u>7/14/59</u>	
PHYSICIAN'S NAME (Type) <u>C. DAVID COOPER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>JUL 20 '59</u>	
ADDRESS <u>4812 Ga Annapolis</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8146

Item 2 Film G246 8-3-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08117

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 1617.2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION KENSINGTON GARDENS		d. STREET ADDRESS 7010-WESTMORELAND AVE.	
3. NAME OF DECEASED (Type or print) First HORACE Middle R Last JENKINS		4. DATE OF DEATH Month July Day 27 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 18-1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBING CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WESLEY JENKINS		14. MOTHER'S MAIDEN NAME MARGARET JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS MARGUERITE L. JENKINS		Address 7010 WESTMORELAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left lung c metastases DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1-2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 59 to July 26, 19 59 , that I last saw the deceased alive on July 20, 19 59 , and that death occurred at 6 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Coleman MD		ADDRESS (Street, city or town, state) 733 Mason Sligo Avenue DATE SIGNED 7/27/59	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN M.D.		Address Silver Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29-1959	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Daraburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walker		ADDRESS 154 Carroll St. N.B.	
24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE William S. Kenna	
DATE JUL 29 '59			

08112

RECEIVED AT THE DEPT. OF THE ARMY

1912

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

THE SECRETARY OF THE ARMY

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THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8077

CERTIFICATE OF DEATH

08118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>3660 16th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Laura Estelle Jennings</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Johnston</u>		14. MOTHER'S MAIDEN NAME <u>Laura Rowland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Ruby J. Groene</u>		Address <u>#5 Glen Drive, Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated duodenal ulcer</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac congestive failure</u> (c) <u>Hypertension and Cardiac Hypertrophy - years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 to 48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 13 1959</u> to <u>July 28</u> , 1959, that I last saw the deceased alive on <u>July 28</u> , 1959, and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u>		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones, MD</u>		DATE SIGNED <u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hines Co.</u>		ADDRESS <u>2901 14th NW</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

0071

00112

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 15 1900</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. Smith</i></p>	
<p>8. Signature of registrar: <i>W. Brown</i></p>	
<p>9. Date of registration: <i>Jan 20 1900</i></p>	
<p>10. Remarks: <i>None</i></p>	

1

8147

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Louisiana b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shreveport 56X-3			
c. LENGTH OF STAY IN 1b 72 days				d. STREET ADDRESS 2912 Devaughn Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Linda Middle Gale Last Jeter		4. DATE OF DEATH Month July Day 8 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1941	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Madison B. Jeter				14. MOTHER'S MAIDEN NAME Cora L. Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X Brönpneumonia, right lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embryonal Rhabdomyosarcoma of pharynx with metastases to lungs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 days 2½ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 27, 1959 to July 8, 1959 , that I last saw the deceased alive on July 8, 1959 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Leon E. Rosenberg M.D.		The Clinical Center		National Institutes of Health		7/8/59	
PHYSICIAN'S NAME (Type) Leon E. Rosenberg, M. D.		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/9/59		22c. NAME OF CEMETERY OR CREMATORY Rose-Neath Funeral Ser.		22d. LOCATION (City, town, or county) (State) Shreveport, La.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 1400 Chapin St. N.W. Wash., D.C.		24a. REC'D BY REGISTRAR DATE JUL 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 & 21 Film 245 7-20-59 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08120

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.			d. STREET ADDRESS 14114 Layhill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Neal Allen Jett			4. DATE OF DEATH Month July Day 3 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/56		9. AGE (in years last birthday) 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Graham Jett		
14. MOTHER'S MAIDEN NAME Martha Gravel			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Graham Jett Address Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning 871.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour - o. m. - p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -		20g. (County) -		20h. (State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/4/59	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/59		22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	
22d. LOCATION (City, town, or county) Gaithersburg, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			
ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUL 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
 10-1-19
 10-1-19

Name of Deceased Robert A. Gaudin		Date of Death 7/1/59	
Place of Death Monte. Co. Gen. Hosp.		Age 71/3/59	
Sex Male		Race White	
Marital Status Married		Occupation None	
Cause of Death Brain Tumor		Manner of Death None	
Contributing Causes Brain Tumor		Medical History Brain Tumor	
Postmortem Examination Brain Tumor		Autopsy Brain Tumor	
Signature of Medical Examiner Frank J. Proschke		Signature of Coroner Robert A. Gaudin	
Date of Signature 7/1/59		Date of Signature 7/1/59	

8149

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Chester Middle Hardy Last JONES				4. DATE OF DEATH Month July Day 21 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-84	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.Coast Guard				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
13. FATHER'S NAME Harlan JONES				14. MOTHER'S MAIDEN NAME Ellen REED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI & WWII			
17. INFORMANT (D) Mrs. Evelyn J. Kinney, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Infarction, myocardium Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 wks 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 24 , 19 59 , to July 21 , 19 59 , that I last saw the deceased alive on July 21 , 19 59 , and that death occurred at 7:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-22-59							
ACTUAL SIGNATURE [Signature]				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR, LCDR, MC, USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines ADDRESS 2901 14th St. NW WDC				24a. REC'D BY REGISTRAR DATE JUL 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08151

CERTIFICATE OF DEATH

2115

DECEASED (Name)

AT HOME

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

(D) Mrs. Dwyer J. Kennedy, aged 42 years

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

DECEASED (Name)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8150

CERTIFICATE OF DEATH

08122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3636 - 16th Street, N. W.	
3. NAME OF DECEASED (Type or print) First Clare Middle Eileen Last Jones		4. DATE OF DEATH Month July Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1902 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Rooney		14. MOTHER'S MAIDEN NAME Clara Nicholls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure at Surgery 411-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Calcific Aortic Stenosis DUE TO (c) Inactive Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 8, 19 59 to July 1, 19 59, that I last saw the deceased alive on July 1, 19 59, and that death occurred at 2:10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE William P. Cornell M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7-1-59
PHYSICIAN'S NAME (Type) William P. Cornell, M. D. National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 4/59	22c. NAME OF CEMETERY OR CREMATORY Warrenton Cemetery	22d. LOCATION (City, town, or county) (State) Warrenton Va.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Moore</u>		ADDRESS <u>Warrenton, Va.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>
		24a. REC'D BY REGISTRAR DATE JUL 6 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8151

CERTIFICATE OF DEATH

Reg. Dist. **08123**

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Bethesda		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban			d. STREET ADDRESS 4000 Cathedral Ave. NW e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) First Fred Middle J. Last Kelly			4. DATE OF DEATH Month 7 Day 31 Year 1959		
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-'80	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educator		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. Yes-Unknown			INFORMANT Mabel Hile Kelly Wife - Sand Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Sigmoid 21 mos (c) Adenocarcinoma of Sigmoid					INTERVAL BETWEEN ONSET AND DEATH one year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July , 19 49 , to July , 19 59 , that I last saw the deceased alive on 7/31 , 19 59 , and that death occurred at 6:45 PM, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)				DATE SIGNED	
ACTUAL SIGNATURE Francis J. Murray M.D. 2111 Bancroft Pl NW Wash DC					
PHYSICIAN'S NAME (Type) FRANCIS J. MURRAY 2111 Bancroft Pl. N. W.				7/31/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
22d. LOCATION (City, town, or county) Rockville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland			24a. REC'D BY REGISTRAR DATE AUG 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MEDICAL CERTIFICATION

08123

D.C.

Washington

Free National Bureau

31

Kelly

7-7-30

U.S.A.

Education Department

Unknown

William Kelly wife Sam

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8152

CERTIFICATE OF DEATH

08124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 20 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XOLNEY d. STREET ADDRESS 1 Rt. #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELINOR		First Clark		Middle MOORE		Last KIRK		4. DATE OF DEATH Month JULY Day 15 Year 19 59	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/24/94		9. AGE (In years lost birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN L. CLARK				14. MOTHER'S MAIDEN NAME Corrinne TALBOTT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast DUE TO (c) Acute Myocardial Infarction								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/11/59 , 19 59 , to 7/15/59 , 19 59 that I last saw the deceased alive on 5/15/59 , 19 59 , and that death occurred at 2:40 P. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE J. W. BIRD, M. D.				ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND				DATE SIGNED 7/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Friends' Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Spring, Montgomery, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Ziska				ADDRESS 8434 Georgia Ave., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUL 17 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2652

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart Notified

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8153

CERTIFICATE OF DEATH

Reg. Dist. No.

08125

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Wyoming	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pineville, 85 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mayme Middle H Last Kirk		4. DATE OF DEATH Month July Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/02
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Lindsay Hambrick		14. MOTHER'S MAIDEN NAME Martha Hypes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT 8411 Westmount Terrace, Bethesda M d.	
17. DAUGHTER (Mrs. Jacquelyn Bron augh)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1. Carcinoma of Lungs with Metastases (c) 2. Fr. Rt. Hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 18, 19 58 to July 21, 1959 , that I last saw the deceased alive on July 21, 19 59 , and that death occurred at 1:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Tuohy		ADDRESS (Street, city or town, state) 7720 Wisconsin Ave Bethesda 14, Md. DATE SIGNED 7/22/59	
PHYSICIAN'S NAME (Type) John H. Tuohy, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 7/22/59	
22c. NAME OF CEMETERY OR CREMATORY Pineville Cem.		22d. LOCATION (City, town, or county) (State) Athens, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

00150

CERTIFICATE OF DEATH

4153

John H. Toney, deceased, Maryland

Winchester, Md.

Robert A. Toney, deceased, Maryland

John H. Toney

Oct 19 1952

1952

00150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8078

CERTIFICATE OF DEATH

08126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Park</u> c. LENGTH OF STAY IN 1b <u>8 1/2 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delphi</u> <u>16x-12</u> d. STREET ADDRESS <u>2207 Hoache Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Barnett</u> Middle <u>Knight</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-11</u>	9. AGE (In years last birthday) <u>47</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>19</u> Min. <u>59</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Conference of S.D.B.</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>			
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Frank H. Knight</u>			14. MOTHER'S MAIDEN NAME <u>Eva E. McClure</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Washington & Hospital record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u>Benign Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Benign Hypertension</u> DUE TO <u>Benign Hypertension</u> (c) <u>Benign Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <u>3 years</u> <u>1954</u> <u>to</u> <u>7/15/1959</u> <u>that I last saw the deceased alive on</u> <u>7/15/1959</u> <u>and that death occurred at</u> <u>837 P.M.</u> <u>from the causes and on the date stated above.</u> ACTUAL SIGNATURE <u>Chas H Wolohin</u> M.D. <u>7600 Carroll Ave</u> ADDRESS (Street, city or town, state) <u>Takoma Park Md</u> DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>		<u>July 17-1959</u>		<u>George Park Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town, or county)		(State)			
<u>Arthur Watter</u>		<u>251 Carroll St. N.B.</u>		<u>Prince Geo's Md.</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<u>JUL 20 '59</u>		<u>Arthur E. Hance</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b <i>DOA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nyattsville</i> <i>1615-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium + Hospital</i>		d. STREET ADDRESS <i>7631 - 25th Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Max</i> Middle <i>Nathaniel</i> Last <i>Kroloff</i>		4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 27, 1908</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BNAI - BRITH</i>	
11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Samuel Kroloff</i>		14. MOTHER'S MAIDEN NAME <i>Mrs. Sarah Helfgott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>254-44-6302</i>	
17. INFORMANT <i>Dr. T. L. Helfgott</i>		Address <i>915-19th St De</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>7-4-59</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>July 6-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. GARD.</i>		22d. LOCATION (City, town, or county) (State) <i>FALLS CHURCH VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. DANZANSKY & SONS - 3501-14th St N.W.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>JUL 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. [Signature]</i>	

40157

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 POSTMEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT.

1

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE		MD.		U.S.A.			
MARRIED		YES		NO		YES		NO		YES		NO		YES		NO	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		OTHER		YES		NO		YES		NO	
OCCUPATION		CLERK		LABORER		FARMER		MERCHANT		PROFESSOR		ARTIST		OTHER			
CAUSE OF DEATH		HEART DISEASE		LUNG DISEASE		KIDNEY DISEASE		STROKE		INFECTION		TRAUMA		SUICIDE		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		HOMICIDE		SUICIDE		OTHER		YES		NO		YES	
DATE OF DEATH		JAN 15 1955		JAN 16 1955		JAN 17 1955		JAN 18 1955		JAN 19 1955		JAN 20 1955		JAN 21 1955		JAN 22 1955	
PLACE OF DEATH		HOME		HOSPITAL		PRISON		OTHER		YES		NO		YES		NO	
SIGNATURE OF EXAMINER		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF EXAMINATION		JAN 15 1955		JAN 16 1955		JAN 17 1955		JAN 18 1955		JAN 19 1955		JAN 20 1955		JAN 21 1955		JAN 22 1955	

STATE OF MARYLAND

NOTARY PUBLIC
 My commission expires on _____
 JAMES H. HARRIS
 Notary Public for the State of Maryland

8080

CERTIFICATE OF DEATH

08128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>51 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
				d. STREET ADDRESS <u>6013 Sudbury Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>(NMM)</u> Last <u>Kronenbitter</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-02</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph OTT</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Loeffler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pyelonephritis left + Bile nephrosis bilateral</u> DUE TO <u>155.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastatic Carcinoma of liver + common bile duct</u> DUE TO <u>Months</u> (c) <u>Primary Carcinoma of Gallbladder + liver</u> <u>years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal ulcer - - has bled recently -</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1959</u> to <u>July 18, 1959</u> , that I last saw the deceased alive on <u>July 17, 1959</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., Silver Spring, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Read N. Calvert</u>				PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D. 7894 Georgia Ave., Silver Spring Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 21 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frawley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete body filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9080

85138

Reg. No. 100

PLACE OF DEATH		RESIDENCE	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	

08129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>10001 Leafy Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>LEE</u> Middle <u>LUCILLE</u> Last <u>R</u>		4. DATE OF DEATH <u>July 17 1959</u> Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-73</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10a. FATHER'S NAME <u>John Henry Whetsel</u>		10b. MOTHER'S MAIDEN NAME <u>Caroline Tucker</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		12. SOCIAL SECURITY NO. <u>—</u>	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Failure</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>59</u> , to <u>7-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-16</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1835 Eye St NW</u> DATE SIGNED <u>5-7-59</u>	
ACTUAL SIGNATURE <u>Marvin M. Gibson</u> M.D. <u>1835 Eye St NW</u>		PHYSICIAN'S NAME (Type) <u>MARVIN M. GIBSON</u> <u>1835 EYE ST. N.W. WASH. DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colonias Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u> ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 of the certificate should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Henry Johnson</i>		AGE <i>7-10</i>		SEX <i>M</i>		RACE <i>N</i>		DATE OF BIRTH <i>7-10-1907</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Student</i>		RELIGION <i>Methodist</i>		MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>7-10-1907</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>		TIME OF DEATH <i>10:30 AM</i>		TEMPERATURE <i>101.0</i>		PULSE <i>120</i>		RESPIRATION <i>30</i>	
SIGNATURE OF PHYSICIAN <i>W. H. Johnson</i>		SIGNATURE OF WITNESSES <i>W. H. Johnson</i>		SIGNATURE OF DECEASED <i>John Henry Johnson</i>		SIGNATURE OF FUNERAL HOME <i>W. H. Johnson</i>		SIGNATURE OF MINISTER <i>W. H. Johnson</i>		SIGNATURE OF CORONER <i>W. H. Johnson</i>	
DATE OF INTERMENT <i>7-10-1907</i>		PLACE OF INTERMENT <i>St. Louis, Mo.</i>		TIME OF INTERMENT <i>10:30 AM</i>		TEMPERATURE <i>101.0</i>		PULSE <i>120</i>		RESPIRATION <i>30</i>	
DATE OF BURIAL <i>7-10-1907</i>		PLACE OF BURIAL <i>St. Louis, Mo.</i>		TIME OF BURIAL <i>10:30 AM</i>		TEMPERATURE <i>101.0</i>		PULSE <i>120</i>		RESPIRATION <i>30</i>	

8155

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Bt. Maryland ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Lewis Last LARSON				4. DATE OF DEATH Month July Day 27 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-59	
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lawrence LARSON				14. MOTHER'S MAIDEN NAME Donna Jean BARRETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 768.0 DUE TO st supsis in newborn infant Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) asphyxia DUE TO (c) infant INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26 , 19 59 , to July 27 , 19 59 , that I last saw the deceased alive on July 27 , 19 59 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-27-59							
ACTUAL SIGNATURE London B. Avery		PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USNR Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 7-30-59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Bradford Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

2051192XV3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05130

CERTIFICATE OF DEATH

1942

1

Married

Married

Married

Married (widow)

U. S. Naval Hospital

Married

Married

Married

Married

Married

Married

Married (widow)

Married (widow)

Married (widow)

Married

Married

1942

1942

U. S. Naval Hospital

A. S. WENT, JR., MD.

1942

1942

1942

8156

CERTIFICATE OF DEATH

08131

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 81 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Daniel Last LEAHY				4. DATE OF DEATH Month July Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-75	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 47 Days X-3		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael LEAHY				14. MOTHER'S MAIDEN NAME Rose HAMILTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) May 1893 to DOD				16. SOCIAL SECURITY NO. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, meningeal vessels, multiple						INTERVAL BETWEEN ONSET AND DEATH 13 hrs. 15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30 , 19 59 , to July 20 , 19 59 that I last saw the deceased alive on July 20 , 19 59 , and that death occurred at 8:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 7/20/59							
ACTUAL SIGNATURE G. I. WALKER, CAPT, MC, USN M.D.				BETHESDA 14, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS Wash., DC				24a. REC'D BY REGISTRAR JUL 22 '59		24b. REGISTRAR'S SIGNATURE Curtis S. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08191

3186

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8157

CERTIFICATE OF DEATH

08132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wheaton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena Rest Home</u>		d. STREET ADDRESS <u>2715 Elmore St Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> First <u>M</u> Middle <u>LEAKIN</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>9</u> Day <u>1959</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Godfrey</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>George G. Leakin</u> Address <u>As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-Sclerosis</u> DUE TO (c) <u>8 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>59</u> , to <u>July 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>59</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>11502 Grandview Ave. Silver Spring, Md.</u>		DATE SIGNED <u>July 9, 1959</u>	
ACTUAL SIGNATURE <u>Belden R. Reap</u>			
PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph & Sons Inc.</u> ADDRESS <u>1556 Pa. Ave N.W. Wash. D.C.</u>		24. REC'D BY REGISTRAR <u>Jul 13 '59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

8158

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08133

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>12 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>812 Islington Street</u>		d. STREET ADDRESS <u>812 Islington Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Angelina Lerario</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>			
13. FATHER'S NAME <u>Francisco Ricciardi</u>		14. MOTHER'S MAIDEN NAME <u>MARY CAMPA</u> <u>Mary Campanella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Silver Spring, Md.</u> <u>Pasquale Lerario 812 Islington Street</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lower intestinal tract with metastasis</u> <u>153.9</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>months</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Frank J. Broschart</u>		DATE SIGNED <u>July 2, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>
22d. LOCATION (City, town, or county) <u>PRINCE GEO. COUNTY, MARYLAND</u>		(State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>GUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Cedric L. Hunt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08134

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3605 ISBELL STREET</u>				e. STREET ADDRESS <u>ISBELL STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DANIEL JOHN</u> First Middle Last <u>Libert</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-21-1920</u>			
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant & financial manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sullivan Bus. Systems</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>John Libert</u>				14. MOTHER'S MAIDEN NAME <u>Irene Gavalar</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> WW LI		16. SOCIAL SECURITY NO. <u>578-03-4521</u>		17. INFORMANT <u>Georgine Libert (wife)</u> Address <u>Illus 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-28-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>trans. & burial</u>		22b. DATE THEREOF <u>8/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dixon, Illinois</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Pumphrey, Inc., Silver Spring, Md.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Brand</u>			

08134

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
23-98 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]	
11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF EXAMINER [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF CORONER [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF JURY [Faint text]	
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79. SIGNATURE OF JURY [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF JURY [Faint text]		82. SIGNATURE OF JURY [Faint text]	
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89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JURY [Faint text]	
91. SIGNATURE OF JURY [Faint text]		92. SIGNATURE OF JURY [Faint text]	
93. SIGNATURE OF JURY [Faint text]		94. SIGNATURE OF JURY [Faint text]	
95. SIGNATURE OF JURY [Faint text]		96. SIGNATURE OF JURY [Faint text]	
97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and signed by the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Item 1 Film 6245 7-21-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8160

CERTIFICATE OF DEATH

Reg. Dist. No.

08135

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>1606 White Oak Dr</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>E.</u> Last <u>LOEHL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Goebel</u>		14. MOTHER'S MAIDEN NAME <u>Leona Nass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Joseph E Zais</u>		Address <u>1606 White Oak Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1951</u> to <u>July 11, 1959</u> , that I last saw the deceased alive on <u>July 8, 1959</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Everett</u> M.D.		ADDRESS (Street, city or town, state) <u>9400 CONN. AVE</u>	
DATE SIGNED <u>7/11/59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		<u>Keensynton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deane Funeral Home</u> ADDRESS <u>4812 Ga An Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hunt</u>			

CERTIFICATE OF DEATH

U.S. MARSHAL SERVICE DEPARTMENT OF HEALTH - BATHING, 18

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U.S. MARSHAL SERVICE
DEPARTMENT OF HEALTH - BATHING, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital for the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8161

CERTIFICATE OF DEATH

08136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> d. STREET ADDRESS <u>2516 TUNLAW RD, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>J.</u> Last <u>LOFTUS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11/22/94</u>
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR <u>8</u> Months <u>6</u> Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Jermann</u>		14. MOTHER'S MAIDEN NAME <u>Salmunen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Helen McGuire</u> Address <u>PG 11 Brandt A. Beth. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25, 1959</u> , to <u>July 27, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D.		DATE SIGNED <u>July 28, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR</u>		ADDRESS (Street, city or town, state) <u>9420 Old Georgetown Rd. Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8162

CERTIFICATE OF DEATH

Reg. Dist. No.

08137

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8416 11th Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER 1616-2	
d. STREET ADDRESS 3251 Queenstown Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BURTON S LOWES		4. DATE OF DEATH JULY 24 Day Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/79
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown Switzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-38-6625	
17. INFORMANT Mrs. Lillian L. Bauman, 8416 11th Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding duodenal ulcer 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10 1959 to July 24 1959 , that I last saw the deceased alive on July 24 1959 , and that death occurred at 5:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6202 Ager Rd., W. Hyattsville, Md. DATE SIGNED 7/24/59 ACTUAL SIGNATURE Ernest J. Parent M.D. PHYSICIAN'S NAME (Type) Ernest J. Parent M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/27/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR JUL 27 59 DATE	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

2165

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		PHYSICIAN'S SIGNATURE [Illegible]	
CORONER'S SIGNATURE [Illegible]		COUNTY CLERK'S SIGNATURE [Illegible]		REGISTRAR'S SIGNATURE [Illegible]	
DATE OF INTERMENT [Illegible]		TIME OF INTERMENT [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]		NAME OF CHURCH [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF SURVIVOR [Illegible]		NAME OF WITNESS [Illegible]	

8163

CERTIFICATE OF DEATH

08138

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Co. b. COUNTY ----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 3704-Military Road N.W.	
3. NAME OF DECEASED (Type or print) First Theodore Middle Mack Last Mack		4. DATE OF DEATH Month July Day 4 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sect.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Mack		14. MOTHER'S MAIDEN NAME Lena Wenger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Dr. Chas. Mack-3704-Military Rd. N.W.		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia, terminal, severe DUE TO (b) Nephrotic, severe DUE TO (c) Arteriosclerosis, generalized severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Hemiplegia, old, severe 2) Diabetes mellitus, moderate		INTERVAL BETWEEN ONSET AND DEATH 2 wks + 10 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to July 4, 1959 , that I last saw the deceased alive on July 4, 1959 , and that death occurred at 9:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St N.W. 7-4-59	
PHYSICIAN'S NAME (Type) Stewart Clapp		M.D. Wash 15 D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7-4-59	
22c. NAME OF CEMETERY OR CREMATORY LEE'S CREMATORY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300 4th St. N.E., Wash. D.C.	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8164

CERTIFICATE OF DEATH

Reg. Dist. No. 08139

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8504 HAZELWOOD DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle KELLEY Last Macy		4. DATE OF DEATH Month JULY Day 15 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) GLENWOOD, IOWA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE I. KELLEY		14. MOTHER'S MAIDEN NAME EMMA OLIVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CECIL W. MACY, 8504 HAZELWOOD DR.		Address BETHESDA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 90 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15, 1959 , to July 15, 1959 , that I last saw the deceased alive on July 12, 1959 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred S. Norton		ADDRESS (Street, city or town, state) Bethesda, Md.	
PHYSICIAN'S NAME (Type) ALFRED S. NORTON		DATE SIGNED 7/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF July 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE 254 CARROLL ST NW.		ADDRESS WASH DC	
24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8165

CERTIFICATE OF DEATH

08140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>34 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>71 Underwood Street, N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Teresa</u> Last <u>Maier</u>			4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1953</u>		9. AGE (In years last birthday) yrs. <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>John C. Maier</u>			14. MOTHER'S MAIDEN NAME <u>Emma Garcia</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>193.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BILATERAL PLEURAL EFFUSIONS</u> DUE TO (c) <u>NEUROBLASTOMA, METASTATIC</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 MOS.</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>59</u> , to <u>July 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>59</u> , and that death occurred at <u>7:10 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Richard C. Mechanic</u>		M.D. <u>The Clinical Center</u>		ADDRESS (Street, city or town, state) <u>The National Institutes of Health</u>	
PHYSICIAN'S NAME (Type) <u>Richard C. Mechanic, M.D.</u>		M.D. <u>Bethesda 14, Maryland</u>		DATE SIGNED <u>7/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Park & Myers, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Mattingly</u>		ADDRESS <u>131-11 St. Wash D.C.</u>		24a. RECEIVED BY REGISTRAR <u>Jul 5 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert H. Mattingly</u>		24c. REGISTRAR'S SIGNATURE <u>Robert H. Mattingly</u>			

05140

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

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DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Dr. Brochart Notified

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18					
8166					
CERTIFICATE OF DEATH					
Reg. Dist. No. 08141					
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY ARLINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL			d. STREET ADDRESS 2500 So. 27th. St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRON Middle MATISKO Last MATISKO			4. DATE OF DEATH Month JULY Day 22 Year 19 59		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.17.29	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months 29 Days 22 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Surgeon		10b. KIND OF BUSINESS OR INDUSTRY BARTLETT TREE CO.		11. BIRTHPLACE (State or foreign country) JESSUP, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME JOHN MATISKO			14. MOTHER'S MAIDEN NAME HELEN VERNO		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES ARMY (KOREAN)			16. SOCIAL SECURITY NO. 192-24-7980		
17. INFORMANT (BROTHER)			360 3rd. St. Lyons Pa		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 330x IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Aneurysm - Circle of Willis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 20 July, 1959 , to 22 July, 1959 , that I last saw the deceased alive on 22 July, 1959 , and that death occurred at 1300 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Norman H. Horurtz			ADDRESS (Street, city or town, state) DATE SIGNED 1150 Conn. Ave. N.W. D.C.		
PHYSICIAN'S NAME (Type) NORMAN H. HORURTZ					
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 7/25/59		22c. NAME OF CEMETERY OR CREMATORY HOLY GHOST CEMETERY	
22d. LOCATION (City, town, or county) (State) JESSUP. LACKAWANNA CO., PA.					
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond R. Ziska			24a. REC'D BY REGISTRAR DATE JUL 27 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

11110

CERTIFICATE OF DEATH

11110

11110

Subscribed and sworn to before me this 11th day of July 1921

Attest my hand and seal this 11th day of July 1921

1120 Comm. on W.D.C.

Norman C. Hammett

8167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4600 SLEAFORD</u>				d. STREET ADDRESS <u>4600 SLEAFORD</u>			
3. NAME OF DECEASED (Type or print) First <u>Infant Boy</u> Middle <u>MCDONOUGH</u> Last <u>MCDONOUGH</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1959</u>	
9. AGE (In years lost birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>3</u>		IF UNDER 24 HRS. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>PAUL M. McDONOUGH</u>				14. MOTHER'S MAIDEN NAME <u>RUTH HELEN STROUP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Father (see above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Separation of Placenta</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22, 1959</u> to <u>July 22, 1959</u> , that I last saw the deceased alive on <u>July 22, 1959</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Kuhn</u>				ADDRESS (Street, city or town, state) <u>4630 MONTGOMERY AVE.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN J. KUHN</u>				DATE SIGNED <u>BETHESDA, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-27-59</u>		<u>ARLINGTON NATIONAL</u>		<u>ARLINGTON, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVoe</u> ADDRESS <u>2224 Wisconsin Dr. E</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

21. Cor. Lee St & Washington D.C.
Bureau 7-27-29 Arlington National

John G. Kinn

Bethesda, Maryland
4330 Montgomery Ave.

July 29

July 29 1:30 PM

No

Paul M. McDonough

Ruth Helen Strong
Father (see above)

Male

Infant Boy

1 x

4300 2 LEAFORD

4300 2 LEAFORD

Bethesda

MARYLAND

MONTGOMERY

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

8168

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY P.R.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21, 16X-2			
				d. STREET ADDRESS 13 Blackhawk Drive, S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Timothy Middle Patrick Last McDougall				4. DATE OF DEATH Month July Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-59	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry H. MC DOUGALL				14. MOTHER'S MAIDEN NAME Elizabeth J. STONE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (M) Mrs. Eliz. McDougall, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3d							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 22 , 19 59 , to July 26 , 19 59 , that I last saw the deceased alive on July 26 , 19 59 , and that death occurred at 9:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-27-59							
ACTUAL SIGNATURE [Signature] M.D. U. S. Naval Hospital 7-27-59							
PHYSICIAN'S NAME (Type) H. A. PEARSON, LT, MC, USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-30-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) (State) Washington D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home				24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10143

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION

NAME: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
SEX: [illegible]
RACE: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MILITARY SERVICE: [illegible]
CIVILIAN SERVICE: [illegible]
REMARKS: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8169
CERTIFICATE OF DEATH

08145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>M ontgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M aryland</u> b. COUNTY <u>M ontgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>M c Ghee</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>M ale</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/59</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wayne M elvin M cGhee</u>		14. MOTHER'S MAIDEN NAME <u>M artha Lou Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wayne M. McGhee-father-same as 2d</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776 x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>11:15 A.M</u> <u>12:45 pm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>59</u> , to <u>July 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Old Georgetown Road Bethesda, Maryland</u> DATE SIGNED <u>7/16/59</u>			
ACTUAL SIGNATURE <u>John M. Wyman</u>		M.D. <u>John M. Wyman, M. D.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24. REC'D BY REGISTRAR <u>Jul 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hume</u>			

2074243/XVO

STATE OF TEXAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1912

1

2

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
LOCAL HEALTH OFFICER

FILED
1912
ATTEST
1912

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

8081

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13, 17 FilmG246 8-6-59 et

Reg. Dist. No.

08144

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San't Hosp.</u>				d. STREET ADDRESS <u>1912 Domer Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles R. McGhee</u>				4. DATE OF DEATH <u>7 24 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1904</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mech Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Charlotte, NC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Robert McGhee</u>				14. MOTHER'S MAIDEN NAME <u>Lula Henson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Nellie McGhee (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Mem. Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Manassas, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 2 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

MEDICAL CERTIFICATION

2

06112

8170

CERTIFICATE OF DEATH

08146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>26 Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Jesse</i> Middle Last <i>Meads</i>				4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>? Sept 16 1883</i>	
9. AGE (In years last birthday) <i>? 75</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Rockville Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>George W. Meads</i>				14. MOTHER'S MAIDEN NAME <i>Rose Rozier</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO.			
INFORMANT <i>Leonard Meades</i>				Address <i>Rockville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic heart disease</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>Years</i> <i>Years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>7-22, 1959</i> , to <i>7-30, 1959</i> , that I last saw the deceased alive on <i>7-29, 1959</i> , and that death occurred at <i>1:00</i> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. G. Hall</i>				ADDRESS (Street, city or town, state) <i>650 Montgomery Ave. Rockville, Md.</i>			
PHYSICIAN'S NAME (Type) <i>W. G. Hall</i>				DATE SIGNED <i>7/30/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>8/3/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Marks,</i>	
22d. LOCATION (City, town, or county) (State) <i>Boyd, Md.</i>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swoolen</i>				ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>AUG 5 59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				DATE			

1 *X*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/58

8171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle D. Last Medler		4. DATE OF DEATH Month July Day 11, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT O. George Medler, Jr.		18. ADDRESS 5133 Blink Drive Valley Brook, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure, acute DUE TO (b) Coronary insufficiency + DUE TO (c) congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 14 hrs. 14 hr. 15 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from (approx) Jan., 19 50 to July 11, 19 59 that I last saw the deceased alive on July 11, 19 59 and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Philip H. Varner, M.D. 10,620 22nd Ave., Wheaton, Md. DATE SIGNED 7/11/59			
ACTUAL SIGNATURE Philip H. Varner		PHYSICIAN'S NAME (Type) Philip H. Varner	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-14-59	
22c. NAME OF CEMETERY OR CREMATORY GEORGE WASH. CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, BETHESDA, MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

917

County of Montgomery State of New York

I, James J. [illegible]

being a duly qualified physician, do hereby certify that on the 10th day of July, 1922

at Albany, New York, I attended the deceased, John J. [illegible]

who died at Albany, New York, at the residence of the deceased, John J. [illegible]

at the age of 65 years, of the disease of Heart Disease

caused by arteriosclerosis

and that the deceased was not suffering from any other disease or condition at the time of death.

Witness my hand and the seal of my office this 10th day of July, 1922.

Attest: James J. [illegible]

Physician

My commission expires on the 10th day of July, 1923.

Subscribed and sworn to before me this 10th day of July, 1922.

Attest: James J. [illegible]

Notary Public

My commission expires on the 10th day of July, 1923.

Attest: James J. [illegible]

Notary Public

CERTIFICATE OF DEATH

Reg. Dist. No.

8172

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>4113 Woodbine St</i>	
3. NAME OF DECEASED (Type or print) First <i>Merle</i> Middle <i>R</i> Last <i>Moffett</i>		4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1896</i>
9. AGE (In years, last birthday) <i>62</i>		IF UNDER 1 YEAR Months <i>24</i> Days <i>11</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Warrenton, U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Moffett</i>		14. MOTHER'S MAIDEN NAME <i>Alice Oaill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Maxwell Moffett - Washington, D. C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>W Gastric hemorrhage.</i> 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>(2) Hepatic Insufficiency.</i> DUE TO (c) <i>(3) Carcinoma of liver (Primary)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>1 wk</i> <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-16</i> , 19 <i>59</i> , to <i>7-31</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7-31</i> , 19 <i>59</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. L. Hall</i>		ADDRESS (Street, city or town, state) <i>615 W. Montgomery Ave. Rockville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>W. L. Hall</i>		DATE SIGNED <i>8/1/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 31, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bristersburg</i>	22d. LOCATION (City, town, or county) (State) <i>Bristersburg, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Suburban - More 1. D. Moore</i>		24a. REC'D BY REGISTRAR <i>DATE AUG 4 '59</i>	
ADDRESS <i>Warrenton, Va.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

Name of Deceased: *Female W*
 Date of Death: *10-14-87*
 Place of Death: *At home*
 Cause of Death: *Heart*
 Age: *71*
 Sex: *Female*
 Race: *White*
 Marital Status: *Married*
 Occupation: *Homemaker*
 Signature of Physician: *[Signature]*
 Signature of Registrar: *[Signature]*
 Date of Registration: *10-14-87*
 Place of Registration: *At home*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08149

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10003 McKenney Ave - Apt 1</u>				d. STREET ADDRESS <u>10003 McKenney Ave - Apt 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Paul</u> Last <u>Morey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1888</u> 71 Yrs.	
9. AGE (in years last birthday) <u>71</u> Yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Business</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u>							
13. FATHER'S NAME <u>Kevin Morey</u>				14. MOTHER'S MARDEN NAME <u>Baldern Ellen Kelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-2719</u>		17. INFORMANT <u>Baldern Morey - Sister 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cormary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-16-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>JUL 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Fuma</u>	

MEDICAL CERTIFICATION

2

00113

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

POST STATE
HEALTH DEPT

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is heavily obscured by faint, illegible markings and bleed-through from the reverse side.

Vertical text on the right margin, likely a filing or processing stamp, containing the words "FBI" and "RECEIVED".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8174

CERTIFICATE OF DEATH

08150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 10 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 6445 Landover Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Mosher		4. DATE OF DEATH Month July Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min.	IF UNDER 24 HRS. Months 7 Days 16 Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Wanda A. Hazell		Address 6445 Old Landover Rd. Landover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 212X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple pulmonary tumors, benign DUE TO (c) Pulmonary abscesses			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month 19 Day 16 Year 19 59 a. m. 4:05p p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jun 16 , 19 59 , to Jul 16 , 19 59 , that I last saw the deceased alive on Jul 16 , 19 59 , and that death occurred at 4:05p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord Street Wash. D.C. DATE SIGNED Jul 16, 1959			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		DATE SIGNED Jul 16, 1959	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 20, 59	22c. NAME OF CEMETERY OR CREMATORY U.S. Soldiers Home	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801 Cleveland Ave.		24. REC'D BY REGISTRAR DATE JUL 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur G. Hume			

CERTIFICATE OF DEATH

1917

08150

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH July 1, 1917		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland		8. OCCUPATION Farmer		9. MARITAL STATUS Married	
10. NAME OF MOTHER Mary Harris		11. NAME OF FATHER John Harris		12. NAME OF SPOUSE Elizabeth Harris	
13. NAME OF PREVIOUS SPOUSE None		14. NAME OF PREVIOUS SPOUSE None		15. NAME OF PREVIOUS SPOUSE None	
16. NAME OF PREVIOUS SPOUSE None		17. NAME OF PREVIOUS SPOUSE None		18. NAME OF PREVIOUS SPOUSE None	
19. NAME OF PREVIOUS SPOUSE None		20. NAME OF PREVIOUS SPOUSE None		21. NAME OF PREVIOUS SPOUSE None	
22. NAME OF PREVIOUS SPOUSE None		23. NAME OF PREVIOUS SPOUSE None		24. NAME OF PREVIOUS SPOUSE None	
25. NAME OF PREVIOUS SPOUSE None		26. NAME OF PREVIOUS SPOUSE None		27. NAME OF PREVIOUS SPOUSE None	
28. NAME OF PREVIOUS SPOUSE None		29. NAME OF PREVIOUS SPOUSE None		30. NAME OF PREVIOUS SPOUSE None	
31. NAME OF PREVIOUS SPOUSE None		32. NAME OF PREVIOUS SPOUSE None		33. NAME OF PREVIOUS SPOUSE None	
34. NAME OF PREVIOUS SPOUSE None		35. NAME OF PREVIOUS SPOUSE None		36. NAME OF PREVIOUS SPOUSE None	
37. NAME OF PREVIOUS SPOUSE None		38. NAME OF PREVIOUS SPOUSE None		39. NAME OF PREVIOUS SPOUSE None	
40. NAME OF PREVIOUS SPOUSE None		41. NAME OF PREVIOUS SPOUSE None		42. NAME OF PREVIOUS SPOUSE None	
43. NAME OF PREVIOUS SPOUSE None		44. NAME OF PREVIOUS SPOUSE None		45. NAME OF PREVIOUS SPOUSE None	
46. NAME OF PREVIOUS SPOUSE None		47. NAME OF PREVIOUS SPOUSE None		48. NAME OF PREVIOUS SPOUSE None	
49. NAME OF PREVIOUS SPOUSE None		50. NAME OF PREVIOUS SPOUSE None		51. NAME OF PREVIOUS SPOUSE None	
52. NAME OF PREVIOUS SPOUSE None		53. NAME OF PREVIOUS SPOUSE None		54. NAME OF PREVIOUS SPOUSE None	
55. NAME OF PREVIOUS SPOUSE None		56. NAME OF PREVIOUS SPOUSE None		57. NAME OF PREVIOUS SPOUSE None	
58. NAME OF PREVIOUS SPOUSE None		59. NAME OF PREVIOUS SPOUSE None		60. NAME OF PREVIOUS SPOUSE None	
61. NAME OF PREVIOUS SPOUSE None		62. NAME OF PREVIOUS SPOUSE None		63. NAME OF PREVIOUS SPOUSE None	
64. NAME OF PREVIOUS SPOUSE None		65. NAME OF PREVIOUS SPOUSE None		66. NAME OF PREVIOUS SPOUSE None	
67. NAME OF PREVIOUS SPOUSE None		68. NAME OF PREVIOUS SPOUSE None		69. NAME OF PREVIOUS SPOUSE None	
70. NAME OF PREVIOUS SPOUSE None		71. NAME OF PREVIOUS SPOUSE None		72. NAME OF PREVIOUS SPOUSE None	
73. NAME OF PREVIOUS SPOUSE None		74. NAME OF PREVIOUS SPOUSE None		75. NAME OF PREVIOUS SPOUSE None	
76. NAME OF PREVIOUS SPOUSE None		77. NAME OF PREVIOUS SPOUSE None		78. NAME OF PREVIOUS SPOUSE None	
79. NAME OF PREVIOUS SPOUSE None		80. NAME OF PREVIOUS SPOUSE None		81. NAME OF PREVIOUS SPOUSE None	
82. NAME OF PREVIOUS SPOUSE None		83. NAME OF PREVIOUS SPOUSE None		84. NAME OF PREVIOUS SPOUSE None	
85. NAME OF PREVIOUS SPOUSE None		86. NAME OF PREVIOUS SPOUSE None		87. NAME OF PREVIOUS SPOUSE None	
88. NAME OF PREVIOUS SPOUSE None		89. NAME OF PREVIOUS SPOUSE None		90. NAME OF PREVIOUS SPOUSE None	
91. NAME OF PREVIOUS SPOUSE None		92. NAME OF PREVIOUS SPOUSE None		93. NAME OF PREVIOUS SPOUSE None	
94. NAME OF PREVIOUS SPOUSE None		95. NAME OF PREVIOUS SPOUSE None		96. NAME OF PREVIOUS SPOUSE None	
97. NAME OF PREVIOUS SPOUSE None		98. NAME OF PREVIOUS SPOUSE None		99. NAME OF PREVIOUS SPOUSE None	
100. NAME OF PREVIOUS SPOUSE None		101. NAME OF PREVIOUS SPOUSE None		102. NAME OF PREVIOUS SPOUSE None	

8175

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 77 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Ballard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barlow d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James MOSS				4. DATE OF DEATH Month Day Year July 10 19 59			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-09	9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rubin MOSS				14. MOTHER'S MAIDEN NAME Emmabelle LUCKETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII & Korean		17. INFORMANT Address (W) Mrs. Audrey Moss, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA, Squamous cell DUE TO (c) 6 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24 , 19 59 , to July 10 , 19 59 , that I last saw the deceased alive on July 10 , 19 59 , and that death occurred at 1:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 7-10-59 ACTUAL SIGNATURE Vernon N Houk M.D. PHYSICIAN'S NAME (Type) VERNON N Houk LTMC USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

24 hours after death. Page 4

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED BY THE ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR, AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN, SHOULD BE FILLED WITH THE FUNERAL DIRECTOR'S SIGNATURE. PAGES 1 AND 2 SHOULD BE FILLED WITH THE FUNERAL DIRECTOR'S SIGNATURE. PAGES 1 AND 2 SHOULD BE FILLED WITH THE FUNERAL DIRECTOR'S SIGNATURE. PAGES 1 AND 2 SHOULD BE FILLED WITH THE FUNERAL DIRECTOR'S SIGNATURE.

VS A15 (4)
15M 9/58

STATE OF TEXAS
CERTIFICATE OF DEATH

8152

08181

212

1

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF MINISTER: [illegible]
SIGNATURE OF CLERK: [illegible]
DATE OF FILING: [illegible]
PLACE OF FILING: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08152

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 TORRINGTON PLACE				d. STREET ADDRESS 400 TORRINGTON PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;">First BESSIEMiddle ELIZABETHLast MULLICAN</div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month JULYDay 3Year 1959</div>			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 14, 1883		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS DAILEY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Theodore E. Mullican, 400 Torrington Pl. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/8/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REG'D BY REGISTRAR JUL 7 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. To execute the certificate, writing forward "pending" in pencil in item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8177

CERTIFICATE OF DEATH

Reg. Dist. No.

08153

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4016 Cleveland Street				d. STREET ADDRESS 4016 Cleveland Street			
3. NAME OF DECEASED (Type or print) First JOHN Middle P Last MUTCHLER				4. DATE OF DEATH Month July Day 5 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1900	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 8 Days 19	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Mutchler				14. MOTHER'S MAIDEN NAME Fidele C. Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2 215-38-5597		17. INFORMANT Ruth B. Mutchler-wife-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis and recent DUE TO (c) Heat Exhaustion						INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from July 5, 1959 to July 5, 1959 , that I last saw the deceased alive on July 5, 1959 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St. N.W.		DATE SIGNED 7.5.59		ADDRESS (Street, city or town, state) Wash D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/8/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03-00000

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please
 TO CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Items 5, 7 Film 6244 7-17-59 et

08155
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY in 1b minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville & Boettler Rds.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 5633 5th Street, North e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hollis Lynn Nicholas		4. DATE OF DEATH Month July Day 10 Year 1959	
5. SEX (M) male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April Aug. 1938
9. AGE (In years last birthday) 21 yrs		10. IF UNDER 1 YEAR Months 1 Days 10	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grand Union Food Store West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elbert M. Nicholas		14. MOTHER'S MAIDEN NAME Olga M. Greathouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 223-46-4443	
17. INFORMANT Police Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 825X DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mr Crushed Chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of auto involved in auto accident 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 2:30 a. m. 7/10/59 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway 20f. (City or town) Silver Spring Montg. Md. (County) (State) 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/10/59 EXAMINER'S NAME (Type) Frank J. Broschart ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) removal 22b. DATE THEREOF 7/10/59 22c. NAME OF CEMETERY OR CREMATORY National Memorial Park Fairfax County Va 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Md. ADDRESS 240. REC'D BY REGISTRAR JUL 13 1959 24b. REGISTRAR'S SIGNATURE Robert S. Frank			

MEDICAL CERTIFICATION

15

2

8179

CERTIFICATE OF DEATH

08156

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN TB <u>14 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>D</u> Last <u>NIELSEN</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>28</u> - Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-87</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FREDERICK W. NIELSEN</u>				14. MOTHER'S MAIDEN NAME <u>ELLA HARDING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-07-9760A</u>			
17. INFORMANT <u>CLAUDE NIELSON JR.</u> Address <u>9908-LOGAN DR.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>3 mos</u> <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 13, 1959</u> , to <u>July 27, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur S. Jay</u>				ADDRESS (Street, city or town, state) <u>Washington Clinic, Washington DC</u>			
DATE SIGNED <u>7/28/59</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Matthew Haulou</u>				ADDRESS <u>3831- La An Nu</u>		24b. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>	
24a. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

2178

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

8180

CERTIFICATE OF DEATH

Reg. Dist. No.

08157

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1903 EAST-WEST HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last O'CONNELL		4. DATE OF DEATH Month JULY Day 31 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/05
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURERS AGENT		10b. KIND OF BUSINESS OR INDUSTRY BUILDING MATERIAL	
11. BIRTHPLACE (State or foreign country) NEVADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL O'CONNELL		14. MOTHER'S MAIDEN NAME MARY CLAWSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth K. O'Connell, 1903 East-West Hwy. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART + RESPIRATORY FAILURE 5 hrs. 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA of ESOPHAGUS 12 weeks DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1959 , to July 31, 1959 , that I last saw the deceased alive on July 31, 1959 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE A. J. Brennan M.D. PHYSICIAN'S NAME (Type) A. J. Brennan			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/3/59	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zuker		24a. REC'D BY REGISTRAR AUG 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2180

08151

PLACE OF BIRTH MARYLAND		USUAL RESIDENCE BALTIMORE	
DATE OF BIRTH 1903		DATE OF DEATH 1903	
SEX MALE		RACE WHITE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH BALTIMORE		MEDICAL ATTENDANT DR. J. H. BROWN	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF MEDICAL ATTENDANT (Signature)	
SIGNATURE OF WITNESS (Signature)		SIGNATURE OF WITNESS (Signature)	



RECEIVED
 BALTIMORE
 1903

8181

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 73 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 8102 Glenbrook Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Last O'NEILL				4. DATE OF DEATH Month July Day 24 Year 1959			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-16-17		9. AGE (In years last birthday) 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius O'NEILL				14. MOTHER'S MAIDEN NAME Mary TIERNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Dec '43 to DOD		16. SOCIAL SECURITY NO. 152-18-6920		INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 Cirrhosis, liver, Laennec's DUE TO (b) 94.15 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12 , 19 59 , to July 24 , 19 59 , that I last saw the deceased alive on July 24 , 19 59 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-25-59							
ACTUAL SIGNATURE Thurman				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR., LCDR, MC, USN				Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS Wash., DC				24a. REC'D BY REGISTRAR JUL 28 '59		24b. REGISTRAR'S SIGNATURE Cirius S. House	
W.W. Chambers Funeral Home, 1400 Chapin St., N.W.							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

2191

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CERTIFICATE OF DEATH

Reg. Dist. No.

08159

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 29 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		d. STREET ADDRESS Route #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James		Middle Thomas		Last Orfield, III		4. DATE OF DEATH Month July		Day 4,		Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1943		9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 16		IF UNDER 24 HRS. Days 16		Hours 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME James T. Orfield, Jr.		14. MOTHER'S MAIDEN NAME Charlotte Salyer													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 226-52-0863		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) Wetrotizing bronchopneumonia Hepato splenomegaly		INTERVAL BETWEEN ONSET AND DEATH 17 months													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from June 5 , 19 59 , to July 4 , 19 59 , that I last saw the deceased alive on July 4 , 19 59 , and that death occurred at 9:15 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 7/4/59											
ACTUAL SIGNATURE Arthur R. Rothman		M.D. The National Institutes of Health		Bethesda 14, Maryland											
PHYSICIAN'S NAME (Type) Arthur R. Rothman, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-7-59		22b. DATE THEREOF 7-7-59		22c. NAME OF CEMETERY OR CREMATORY Knollkreg Cemetery		22d. LOCATION (City, town, or county) Washington County, Va.									
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '59		24b. REGISTRAR'S SIGNATURE Arthur R. Rothman									

10130

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1882

Veranda
TAMM ROAD

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Witness	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Farmer		Heart Disease		Jan 15, 1900		Home		Dr. J. Smith		J. Doe		J. Smith		J. Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8082

CERTIFICATE OF DEATH

Reg. Dist. No. 08160

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>32 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. & Hosp.</u>				e. STREET ADDRESS <u>507 Greenlaw Dr.</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Suzanne</u> Middle <u>N.M.N.</u> Last <u>Oser</u>				4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-11-95</u>	
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>15</u> Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Russian</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Natholi Katz</u>				14. MOTHER'S MAIDEN NAME <u>Japhia Katz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>186-18-6709</u>			
17. INFORMANT <u>Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation - small bowel c obstruction</u> <u>572.1</u> DUE TO <u>Dysenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u> (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>1 mo -</u> <u>long standing</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Hour <u>o. m.</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>July 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>59</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Eugene A. Dorso M.D.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
<u>Burial</u>				<u>7/22-1959</u>			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
<u>Geo Wash Cemetery</u>				<u>Hyattsville MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soldberg Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>			
ADDRESS <u>Washington</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carlene Middle (none) Last Otis				4. DATE OF DEATH Month July Day 1 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 7, 1942	
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LeRoy M. Otis				14. MOTHER'S MAIDEN NAME Augusta Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.3 Congestive heart failure DUE TO (b) Chronic lung disease DUE TO (c) Cystic fibrosis of pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 587.3				INTERVAL BETWEEN ONSET AND DEATH 3 2 yrs 10 yrs —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 5, 19 59 to July 1, 19 59 , that I last saw the deceased alive on July 1, 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George M. Owen M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7-1-59			
PHYSICIAN'S NAME (Type) George M. Owen, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-59		22c. NAME OF CEMETERY OR CREMATORY Edwards Cemetery		22d. LOCATION (City, town, or county) (State) Calver Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 3. Basch's Sons Hyattsville, Md.				24. REC'D BY REGISTRAR DATE JUL 6 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hauer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>IMMEDIATE CAUSE OF DEATH [Faint text]</p>	
<p>PERMANENT CAUSE OF DEATH [Faint text]</p>		<p>DATE OF EXAMINATION [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>	

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		d. STREET ADDRESS 3701 MASS. AVE., NW, apt 610	
3. NAME OF DECEASED (Type or print) GRACE First ISABELLE Middle PALMER Last		4. DATE OF DEATH Month JULY Day 4 Year 1959	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/24
9. AGE (In years last birthday) yrs. 34		IF UNDER 1 YEAR Months 7 Days 4 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAIR		10b. KIND OF BUSINESS OR INDUSTRY HAIR	
11. BIRTHPLACE (State or foreign country) VIETNAM		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HENRY		14. MOTHER'S MAIDEN NAME NORMA WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma in liver 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3+ mo. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1959 to July 4, 1959 that I last saw the deceased alive on July 3, 1959 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. P. McNeill		M.D. 1600 Carroll Ave	
PHYSICIAN'S NAME (Type) W. P. McNeill, M.D.		ADDRESS (Street, city or town, state) Takoma Park 12, MD	
DATE SIGNED 7/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-7-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) SUITLAND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Joe. Sawler's Sons		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
24b. REGISTRAR'S SIGNATURE William S. Kountz			

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG246 8-3-59 et

CERTIFICATE OF DEATH

8184

Reg. Dist. No. 08163

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>At home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Celia</i> Middle <i>Anna</i> Last <i>Parezo</i>				4. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 14, 1879</i>	
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employed by Gov. Gov. Employ</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov. Employ</i>	
11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Warren B. Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Eloza Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mrs. Fannie Davidson-Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure due to cardiac hypertrophy. Renal calculi with years</i> DUE TO (b) <i>hypertrophy. Renal calculi with years</i> DUE TO (c) <i>lymphonephrosis right. Pyelonephritis years</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hiatal Hernia, Diverticularis of sigmoid colon</i>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>June 28, 1959</i> , to <i>July 29, 1959</i> , that I last saw the deceased alive on <i>July 26</i> , 19 <i>59</i> , and that death occurred at <i>11</i> A.M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <i>Philip E. Jones</i>		M.D. <i>918 Ellsworth Drive</i>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring, Md</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>8/1/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>George Wash. Mem. Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Company</i>		24a. REC'D BY REGISTRAR <i>2901 14th St. N.W. Washington 9, D.C.</i>	
24b. REGISTRAR'S SIGNATURE <i>Julius S. Hines</i>		DATE <i>JUL 30 '59</i>		24c. REGISTRAR'S SIGNATURE		DATE	

CERTIFICATE OF DEATH

2184

10-153

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 15, 1924</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>[Signature]</i></p>	
<p>8. Signature of registrar: <i>[Signature]</i></p>	
<p>9. Date of registration: <i>Jan 16, 1924</i></p>	
<p>10. Place of registration: <i>Baltimore</i></p>	
<p>11. Name of informant: <i>John Doe</i></p>	
<p>12. Address of informant: <i>123 Main St</i></p>	
<p>13. City: <i>Baltimore</i></p>	
<p>14. State: <i>Md</i></p>	
<p>15. County: <i>Baltimore</i></p>	
<p>16. District: <i>1</i></p>	
<p>17. Ward: <i>1</i></p>	
<p>18. Block: <i>1</i></p>	
<p>19. Lot: <i>1</i></p>	
<p>20. Sublot: <i>1</i></p>	
<p>21. Section: <i>1</i></p>	
<p>22. Block: <i>1</i></p>	
<p>23. Lot: <i>1</i></p>	
<p>24. Sublot: <i>1</i></p>	
<p>25. Section: <i>1</i></p>	
<p>26. Block: <i>1</i></p>	
<p>27. Lot: <i>1</i></p>	
<p>28. Sublot: <i>1</i></p>	
<p>29. Section: <i>1</i></p>	
<p>30. Block: <i>1</i></p>	
<p>31. Lot: <i>1</i></p>	
<p>32. Sublot: <i>1</i></p>	
<p>33. Section: <i>1</i></p>	
<p>34. Block: <i>1</i></p>	
<p>35. Lot: <i>1</i></p>	
<p>36. Sublot: <i>1</i></p>	
<p>37. Section: <i>1</i></p>	
<p>38. Block: <i>1</i></p>	
<p>39. Lot: <i>1</i></p>	
<p>40. Sublot: <i>1</i></p>	
<p>41. Section: <i>1</i></p>	
<p>42. Block: <i>1</i></p>	
<p>43. Lot: <i>1</i></p>	
<p>44. Sublot: <i>1</i></p>	
<p>45. Section: <i>1</i></p>	
<p>46. Block: <i>1</i></p>	
<p>47. Lot: <i>1</i></p>	
<p>48. Sublot: <i>1</i></p>	
<p>49. Section: <i>1</i></p>	
<p>50. Block: <i>1</i></p>	
<p>51. Lot: <i>1</i></p>	
<p>52. Sublot: <i>1</i></p>	
<p>53. Section: <i>1</i></p>	
<p>54. Block: <i>1</i></p>	
<p>55. Lot: <i>1</i></p>	
<p>56. Sublot: <i>1</i></p>	
<p>57. Section: <i>1</i></p>	
<p>58. Block: <i>1</i></p>	
<p>59. Lot: <i>1</i></p>	
<p>60. Sublot: <i>1</i></p>	
<p>61. Section: <i>1</i></p>	
<p>62. Block: <i>1</i></p>	
<p>63. Lot: <i>1</i></p>	
<p>64. Sublot: <i>1</i></p>	
<p>65. Section: <i>1</i></p>	
<p>66. Block: <i>1</i></p>	
<p>67. Lot: <i>1</i></p>	
<p>68. Sublot: <i>1</i></p>	
<p>69. Section: <i>1</i></p>	
<p>70. Block: <i>1</i></p>	
<p>71. Lot: <i>1</i></p>	
<p>72. Sublot: <i>1</i></p>	
<p>73. Section: <i>1</i></p>	
<p>74. Block: <i>1</i></p>	
<p>75. Lot: <i>1</i></p>	
<p>76. Sublot: <i>1</i></p>	
<p>77. Section: <i>1</i></p>	
<p>78. Block: <i>1</i></p>	
<p>79. Lot: <i>1</i></p>	
<p>80. Sublot: <i>1</i></p>	
<p>81. Section: <i>1</i></p>	
<p>82. Block: <i>1</i></p>	
<p>83. Lot: <i>1</i></p>	
<p>84. Sublot: <i>1</i></p>	
<p>85. Section: <i>1</i></p>	
<p>86. Block: <i>1</i></p>	
<p>87. Lot: <i>1</i></p>	
<p>88. Sublot: <i>1</i></p>	
<p>89. Section: <i>1</i></p>	
<p>90. Block: <i>1</i></p>	
<p>91. Lot: <i>1</i></p>	
<p>92. Sublot: <i>1</i></p>	
<p>93. Section: <i>1</i></p>	
<p>94. Block: <i>1</i></p>	
<p>95. Lot: <i>1</i></p>	
<p>96. Sublot: <i>1</i></p>	
<p>97. Section: <i>1</i></p>	
<p>98. Block: <i>1</i></p>	
<p>99. Lot: <i>1</i></p>	
<p>100. Sublot: <i>1</i></p>	
<p>101. Section: <i>1</i></p>	
<p>102. Block: <i>1</i></p>	
<p>103. Lot: <i>1</i></p>	
<p>104. Sublot: <i>1</i></p>	
<p>105. Section: <i>1</i></p>	
<p>106. Block: <i>1</i></p>	
<p>107. Lot: <i>1</i></p>	
<p>108. Sublot: <i>1</i></p>	
<p>109. Section: <i>1</i></p>	
<p>110. Block: <i>1</i></p>	
<p>111. Lot: <i>1</i></p>	
<p>112. Sublot: <i>1</i></p>	
<p>113. Section: <i>1</i></p>	
<p>114. Block: <i>1</i></p>	
<p>115. Lot: <i>1</i></p>	
<p>116. Sublot: <i>1</i></p>	
<p>117. Section: <i>1</i></p>	
<p>118. Block: <i>1</i></p>	
<p>119. Lot: <i>1</i></p>	
<p>120. Sublot: <i>1</i></p>	
<p>121. Section: <i>1</i></p>	
<p>122. Block: <i>1</i></p>	
<p>123. Lot: <i>1</i></p>	
<p>124. Sublot: <i>1</i></p>	
<p>125. Section: <i>1</i></p>	
<p>126. Block: <i>1</i></p>	
<p>127. Lot: <i>1</i></p>	
<p>128. Sublot: <i>1</i></p>	
<p>129. Section: <i>1</i></p>	
<p>130. Block: <i>1</i></p>	
<p>131. Lot: <i>1</i></p>	
<p>132. Sublot: <i>1</i></p>	
<p>133. Section: <i>1</i></p>	
<p>134. Block: <i>1</i></p>	
<p>135. Lot: <i>1</i></p>	
<p>136. Sublot: <i>1</i></p>	
<p>137. Section: <i>1</i></p>	
<p>138. Block: <i>1</i></p>	
<p>139. Lot: <i>1</i></p>	
<p>140. Sublot: <i>1</i></p>	
<p>141. Section: <i>1</i></p>	
<p>142. Block: <i>1</i></p>	
<p>143. Lot: <i>1</i></p>	
<p>144. Sublot: <i>1</i></p>	
<p>145. Section: <i>1</i></p>	
<p>146. Block: <i>1</i></p>	
<p>147. Lot: <i>1</i></p>	
<p>148. Sublot: <i>1</i></p>	
<p>149. Section: <i>1</i></p>	
<p>150. Block: <i>1</i></p>	
<p>151. Lot: <i>1</i></p>	
<p>152. Sublot: <i>1</i></p>	
<p>153. Section: <i>1</i></p>	
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<p>344. Sublot: <i>1</i></p>	
<p>345. Section: <i>1</i></p>	
<p>346. Block: <i>1</i></p>	
<p>347. Lot: <i>1</i></p>	
<p>348. Sublot</p>	

8185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9506-Lindale Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Hall Last Patterson		4. DATE OF DEATH Month July Day 5 Year 19 59	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1889
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Hall	
14. MOTHER'S MAIDEN NAME Emily Schwarz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Shirley Barrett-9506-Lindale Drive, Bethesda	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Carcinomatosis DUE TO (b) Carcinoma of colon DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral hydronephrosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 27 , 19 59 , to July 5 , 19 59 , that I lost saw the deceased alive on July 4 , 19 59 , and that death occurred at M , from the causes and on the date stated above. Has been under close supervision of my associate, Dr. Thomas L. Hartman (of same address) ACTUAL SIGNATURE Geo. Buchanan M.D. ADDRESS 1834 Eye St. N.W., Washington, D.C. DATE SIGNED 7/4/59 PHYSICIAN'S NAME (Type) George Buchanan, M.D. 1834 Eye St. N. W. Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 7/9/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Bronx, New York
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUL 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

8186

CERTIFICATE OF DEATH

Reg. Dist. No.

08165

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle J. Last Patterson		4. DATE OF DEATH Month July Day 16, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1880
9. AGE (In years last birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Gass	
14. MOTHER'S MAIDEN NAME Triphena Marcy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Gilbert K. Greene Address 4630 Davenport St. Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) ASCD + Acute Myocardial Inf. DUE TO ASCD (c) ? INTERVAL BETWEEN ONSET AND DEATH 1 hr 7 days			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 July , 19 59 , to 16 July , 19 59 , that I last saw the deceased alive on 16 July , 19 59 , and that death occurred at 2:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1114 Army Navy Dr., Arl., Va. DATE SIGNED 16 July 59 ACTUAL SIGNATURE Joseph E. Shuman M.D. 1114 Army Navy Dr., Arl., Va. PHYSICIAN'S NAME (Type) Joseph E. Shuman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7/17/1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE JUL 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Henry J. Jackson

Office of the Secretary of the Interior

Washington, D.C.

Department of the Interior

Office of the Secretary of the Interior

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08166

8187

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Turbarban</i>		d. STREET ADDRESS <i>10015 Quindby Court</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Elisha King Payne</i>		4. DATE OF DEATH Month Day Year <i>July 1 19 59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30 1876</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Penn. Railroad</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Treat Payne</i>		14. MOTHER'S MAIDEN NAME <i>---Ellis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT Address <i>Sandy Catherine G. Thompson - Daughter</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/8/52</i> , 19 <i>52</i> , to <i>7/1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7/1</i> , 19 <i>59</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John E. Everett</i> M.D.		ADDRESS (Street, city or town, state) <i>9400 Corn Ave Kensington Md</i>	
DATE SIGNED <i>7/1/59</i>			
PHYSICIAN'S NAME (Type) <i>JOHN E EVERETT</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/6/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery Alexandria, Va.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. REC'D BY REGISTRAR <i>2901 14th St. N.W. Washington 9, D.C.</i>	
DATE <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Hines</i>	

CERTIFICATE OF DEATH

2152

King

April 24 1974

Corporal James Earl Ray

Street 101
No 10

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21

21/25

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8091

CERTIFICATE OF DEATH

Reg. Dist. No.

08167

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 26	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 904 Wesley Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 904 Wesley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last PERRY		4. DATE OF DEATH Month July Day 21 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/1882
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 5 Days 20 Hours 20 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Utterback		14. MOTHER'S MAIDEN NAME Sally E. Koffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Virgie O. Dailey-sister-above address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 10+ yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1959 , to July 20, 1959 that I last saw the deceased alive on July 20, 1959 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Bowditch Hunter, Jr.		ADDRESS (Street, city or town, state) 809 Veirs Mill Rd. Rockville, Md.	
PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		DATE SIGNED 7/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-59	
22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR JUL 24 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

08103

EXP. DATE: 11/1/83

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8188

CERTIFICATE OF DEATH

Reg. Dist. No. 08168

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8857 GARLAND AVENUE APT. #12				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DOUGLASS NEIL PORTER				4. DATE OF DEATH JULY 14 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1930	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER, MAJOR FINANCE CO. LOAN CO.				10b. KIND OF BUSINESS OR INDUSTRY WEARTON, ONTARIO		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME ALBERT PORTER				14. MOTHER'S MAIDEN NAME MARY SPICER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-52-2368		17. INFORMANT MRS. JEANNETTE PORTER, 8857 GARLAND AVE. SILVER			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA OF THE LEFT TESTICLE WITH GENERALIZED METASTASIS DUE TO 178X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1958 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH AUGUST	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from OCT. 1958 to JULY 1959 , that I last saw the deceased alive on 11 JULY 1959 , and that death occurred at 6P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Reaumur S. Donnelly		ADDRESS (Street, city or town, state) 1827 23rd ST. NW		DATE SIGNED 7/15/59			
PHYSICIAN'S NAME (Type) REAUMUR S. DONNELLY MD. WASHINGTON DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 17, 1959	22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEMETERY PRINCE GEORGE'S COUNTY, MD.	22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS 8434 Georgia Ave., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUL 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Myocardial Infarction

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin G. Potter</u>		4. DATE OF DEATH Month Day Year <u>July 5 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1873</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Potter</u>		14. MOTHER'S MAIDEN NAME <u>Miriam Ogden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wife</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO <u>Arteriosclerosis, gen eral and coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO <u>—</u> (c) DUE TO <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>59</u> to <u>July 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>59</u> , and that death occurred at <u>2:25P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Agle</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5009 Del Ray Ave, Bethesda, Md 7/5/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Agle, M.D.</u>		<u>5009 Del Ray Avenue, Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

VS A15 (4)
15M 9/58

1893

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10 YEARS

10 YEARS

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TO DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8190 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL) Bethesda c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7659 Old Georgetown Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4810 Rugby Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Lawrence Potter		4. DATE OF DEATH July 10 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/59
9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert H. Potter		14. MOTHER'S MAIDEN NAME Roberta E. Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Herbert H Potter-father-2d		Address Suburban Hosp. Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 763.0 (c), stating the underlying cause lost. DUE TO (c) 763.0		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2074315XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08171

Reg. Dist. No.

8191

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 33 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10122 CAPITOL VIEW AVENUE		d. STREET ADDRESS 10122 CAPITOL VIEW AVENUE	
3. NAME OF DECEASED (Type or print) JACOB JOSEPH RABBITT		4. DATE OF DEATH Month JULY Day 13 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 16, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS S. RABBITT		14. MOTHER'S MAIDEN NAME MARTHA JANE KEMP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-5707	
17. INFORMANT Mrs. Blance E. Rabbitt		Address Silver Spring, Md. 10122 Capitol View Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Hypertention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/15/59	
22c. NAME OF CEMETERY OR CREMATORY Rockville Union Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md. Raymond A. Ziska		24a. REC'D BY REGISTRAR JUL 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the Signatures of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00151

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2151

FOR STATE
DEATH CERT.

1. Name of deceased: WILLIAM J. BROWN

2. Sex: Male

3. Age: 45

4. Date of death: 10-15-1918

5. Place of death: Home

6. Cause of death: Heart Disease

7. Manner of death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of examination: 10-15-1918

10. Place of examination: Home

11. Name of attending physician: [Signature]

12. Date of consultation: 10-15-1918

13. Name of hospital: [Blank]

14. Date of admission: [Blank]

15. Name of physician: [Blank]

16. Date of discharge: [Blank]

17. Name of physician: [Blank]

18. Date of discharge: [Blank]

19. Name of physician: [Blank]

20. Date of discharge: [Blank]

21. Name of physician: [Blank]

22. Date of discharge: [Blank]

23. Name of physician: [Blank]

24. Date of discharge: [Blank]

25. Name of physician: [Blank]

26. Date of discharge: [Blank]

27. Name of physician: [Blank]

28. Date of discharge: [Blank]

29. Name of physician: [Blank]

30. Date of discharge: [Blank]

31. Name of physician: [Blank]

32. Date of discharge: [Blank]

33. Name of physician: [Blank]

34. Date of discharge: [Blank]

35. Name of physician: [Blank]

36. Date of discharge: [Blank]

37. Name of physician: [Blank]

38. Date of discharge: [Blank]

39. Name of physician: [Blank]

40. Date of discharge: [Blank]

41. Name of physician: [Blank]

42. Date of discharge: [Blank]

43. Name of physician: [Blank]

44. Date of discharge: [Blank]

45. Name of physician: [Blank]

46. Date of discharge: [Blank]

47. Name of physician: [Blank]

48. Date of discharge: [Blank]

49. Name of physician: [Blank]

50. Date of discharge: [Blank]

51. Name of physician: [Blank]

52. Date of discharge: [Blank]

53. Name of physician: [Blank]

54. Date of discharge: [Blank]

55. Name of physician: [Blank]

56. Date of discharge: [Blank]

57. Name of physician: [Blank]

58. Date of discharge: [Blank]

59. Name of physician: [Blank]

60. Date of discharge: [Blank]

61. Name of physician: [Blank]

62. Date of discharge: [Blank]

63. Name of physician: [Blank]

64. Date of discharge: [Blank]

65. Name of physician: [Blank]

66. Date of discharge: [Blank]

67. Name of physician: [Blank]

68. Date of discharge: [Blank]

69. Name of physician: [Blank]

70. Date of discharge: [Blank]

71. Name of physician: [Blank]

72. Date of discharge: [Blank]

73. Name of physician: [Blank]

74. Date of discharge: [Blank]

75. Name of physician: [Blank]

76. Date of discharge: [Blank]

77. Name of physician: [Blank]

78. Date of discharge: [Blank]

79. Name of physician: [Blank]

80. Date of discharge: [Blank]

81. Name of physician: [Blank]

82. Date of discharge: [Blank]

83. Name of physician: [Blank]

84. Date of discharge: [Blank]

85. Name of physician: [Blank]

86. Date of discharge: [Blank]

87. Name of physician: [Blank]

88. Date of discharge: [Blank]

89. Name of physician: [Blank]

90. Date of discharge: [Blank]

91. Name of physician: [Blank]

92. Date of discharge: [Blank]

93. Name of physician: [Blank]

94. Date of discharge: [Blank]

95. Name of physician: [Blank]

96. Date of discharge: [Blank]

97. Name of physician: [Blank]

98. Date of discharge: [Blank]

99. Name of physician: [Blank]

100. Date of discharge: [Blank]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08172	
8192										CERTIFICATE OF DEATH	
										Reg. Dist. No. 215	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4000 Cathedral Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last John Kelvey RICHARDS					4. DATE OF DEATH Month Day Year July 25 1959						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-20-91		9. AGE (In years last birthday) yrs. 68			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy			10b. KIND OF BUSINESS OR INDUSTRY Government			11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John K. RICHARDS					14. MOTHER'S MAIDEN NAME Anna STEECE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1908-1945					INFORMANT Address (Wife) Dorothy D. RICHARDS Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm, aorta, dissecting 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pheochromocytoma, left adrenal										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 22 July , 19 59 , to 25 July , 19 59 , that I last saw the deceased alive on 25 July , 19 59 , and that death occurred at 4:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED LeRoy E. Kurth Jr. M.D. U.S. Naval Hospital, NMMC, Bethesda Md.											
ACTUAL SIGNATURE LeRoy E. Kurth Jr. PHYSICIAN'S NAME (Type) LeRoy E. Kurth Jr., LT, MC, USN U.S. Naval Hospital, NMMC, Bethesda Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7-28-59			22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS WASH. D.C. 1400 Chapin St. N.W.						24a. REC'D BY REGISTRAR JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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W.B. 1. 2. 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8193

CERTIFICATE OF DEATH

Reg. Dist. No.

08173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Brent</u> Middle <u>Taylor</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1953</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Garrison L. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Gibbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postoperative cardiac arrhythmia</u> DUE TO <u>754.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tetralogy of Fallot</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>8 Hours</u> Birth							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>59</u> , to <u>July 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>59</u> , and that death occurred at <u>3:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>7-10-59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>E. Kent Carney M.D.</u>				PHYSICIAN'S NAME (Type) <u>E. Kent Carney, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 11, 1959</u>		<u>Crest Haven Cemetery</u>		<u>Mitchell, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thoms</u>			

CERTIFICATE OF DEATH

210

NAME OF DECEASED

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CORPSE

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

NAME OF BURIAL

NAME OF INTERMENT

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8194

CERTIFICATE OF DEATH

Reg. Dist. No.

08174

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>				c. LENGTH OF STAY IN 1b <u>22 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank E. Russell</u>				4. DATE OF DEATH Month Day Year <u>July 1 1959</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12, 1899</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>19</u>		11. IF UNDER 24 HRS. <u>9</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comm. of Customs</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury</u>			
11. BIRTHPLACE (State or foreign country) <u>Birmingham, Alabama</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Samuel Andrew Russell</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Robbins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>P.O.T.C. WWII</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANS MURAL Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>			
18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-12-1959</u> to <u>7-1-1959</u> , that I last saw the deceased alive on <u>7-1-1959</u> , and that death occurred at <u>120 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St. NW</u>				<u>7-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Wash 15 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-3-59</u>		<u>Columbia Gardens Cem.</u>		<u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>Robert A. Pumphrey - Bethesda, Maryland</u>							
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
<u>JUL 6 '59</u>				<u>C. L. B. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG244 7-17-59 et
8195 CERTIFICATE OF DEATH

Reg. Dist. No. 08175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>06X.2</u> <u>Sykesville (Father is Dr. at State Hosp.)</u>			
c. LENGTH OF STAY IN 1b <u>109 days</u>				d. STREET ADDRESS <u>Springfield State Hospital</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Luis</u> Middle <u>(none)</u> Last <u>Santos</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 59</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1955</u>	9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>Mexico</u>	
13. FATHER'S NAME <u>Luis Santos</u>				14. MOTHER'S MAIDEN NAME <u>Noemi Lopez</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute lymphocytic leukemia</u> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gastrointestinal hemorrhage</u> DUE TO (c) <u>Renal hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17</u> , 19 <u>59</u> , to <u>July 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>59</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>7/4/59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Arthur R. Rothman</u>		M.D. <u>The Clinical Center</u>					
PHYSICIAN'S NAME (Type) <u>Arthur R. Rothman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>El. Sancito</u>		22d. LOCATION (City, town, or county) (State) <u>San Luis Potosi, Mexico</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>7/7/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Z'raus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8196 CERTIFICATE OF DEATH

08176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN lb <u>7 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>9311 Longbranch Pkwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILDA</u> Middle <u>F.</u> Last <u>SCHAEFER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>4/5/88</u>		9. AGE (In years last birthday) <u>71 yrs.</u>		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Goshen, Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel Brubaker</u>				14. MOTHER'S MAIDEN NAME <u>Florence Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-03-9543</u>		INFORMANT <u>Daughter (Mrs. Mary Newton)</u> Address <u>100 Emerson St. N.W. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>142.9</u> DUE TO <u>Cerebral Ischemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shock following Postop. Cardiac Arrest</u> (c) <u>Colitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mixed Salivary Gland Tumor Rt. Throat</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>July 16, 1959</u> , to <u>July 24, 1959</u> , that I last saw the deceased alive on <u>July 23, 1959</u> , and that death occurred at <u>10:31 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John P. Haberlin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOHN P. HABERLIN</u> <u>927 Persing Dr. Silver Spring, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>		24a. REC'D JUL 27 1959					
24b. REGISTRAR'S SIGNATURE <u>Raymond E. Ziska</u>		24c. REGISTRAR'S SIGNATURE <u>Raymond E. Ziska</u>					

Dr. Brochart Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01136

CENTRAL OF CHINA

2106

100-100000

RECEIVED

100-100000

8197

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08177

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8.0 A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8209 Flower Ave</u>				d. STREET ADDRESS <u>9502 Skybrooke Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First LEROY Middle SCHRIDER Last <u>John Leroy Schrider</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 24, 1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES EDWARD SCHRIDER</u>				14. MOTHER'S MAIDEN NAME <u>THERESA LAVINIA McCAULEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-5119</u>		17. INFORMANT <u>Joe W. Scott Jr.</u> Address <u>208 E. Hamilton Ave Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MONTGOMERY CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Piska</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8198

CERTIFICATE OF DEATH

08178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRG.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>19503 HALE PL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL</u> - <u>SCHWARTZ</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>3</u> 19 <u>59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WH.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 4-1916</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVT. EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY DEPT</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ISADORE SCHWARTZ</u>				14. MOTHER'S MAIDEN NAME <u>CELIA SARAGO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>YES</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>160-14-0281</u>			
				17. INFORMANT Address <u>ROTH M. SCHWARTZ 9503 HALE PL. S.S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>32 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>57</u> , to <u>July 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Evans</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>July 3 901 23rd St N.W., City</u>			
PHYSICIAN'S NAME (Type) <u>W. M. EVANS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARL. NATL. Cem.</u>		22d. LOCATION (City, town or county) (State) <u>ARL. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>GOLDBERG FUNERAL HOME 4217-9th</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10178

8197

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>		4. DATE OF BIRTH <u>10-15-1912</u>		5. PLACE OF BIRTH <u>NEW YORK, N.Y.</u>		6. OCCUPATION <u>CLERK</u>	
7. MARITAL STATUS <u>MARRIED</u>		8. RACE <u>WHITE</u>		9. RELIGION <u>CATHOLIC</u>		10. EDUCATION <u>HIGH SCHOOL</u>		11. SOCIAL SECURITY NUMBER <u>1-23-456789</u>		12. PLACE OF DEATH <u>HOME</u>	
13. DATE OF DEATH <u>11-10-1957</u>		14. TIME OF DEATH <u>10:30 AM</u>		15. CAUSE OF DEATH <u>HEART DISEASE</u>		16. MANNER OF DEATH <u>NATURAL</u>		17. PLACE OF INTERMENT <u>CATHOLIC CHURCH</u>		18. SIGNATURE OF REGISTRAR <u>[Signature]</u>	
19. SIGNATURE OF DECEASED <u>[Signature]</u>		20. SIGNATURE OF NEXT OF KIN <u>[Signature]</u>		21. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		22. SIGNATURE OF CORONER <u>[Signature]</u>		23. SIGNATURE OF JURY <u>[Signature]</u>		24. SIGNATURE OF WITNESSES <u>[Signature]</u>	



THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY FALSIFICATION OR MISUSE OF THIS RECORD IS A VIOLATION OF THE LAW AND IS SUBJECT TO PROSECUTION.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08179

Reg. Dist. No.

8092

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Richland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mansfield</u>		72 x - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial motel</u>				d. STREET ADDRESS <u>214 Rowland Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Harry</u> Last <u>Shade</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1916</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Warner Shade</u>				14. MOTHER'S MAIDEN NAME <u>Louise Damlos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 2 297-09-4959</u>		17. INFORMANT <u>Clara Shade (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>	Month, Day, Year <u>7/29/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-29-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mansfield Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Richland County, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Montgomery Co. Medical Examiner notified.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08180									
8199										CERTIFICATE OF DEATH									
Reg. Dist. No. 215																			
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 3 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas 83X-3												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					d. STREET ADDRESS E Rt. #1, Box 41					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Henry			First Tilman		Middle SHIELDS		Last SHIELDS		4. DATE OF DEATH Month July		Day 16		Year 19 59						
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-18-00		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59		IF UNDER 24 HRS. Days 59		Hours 59		Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney					10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service					11. BIRTHPLACE (State or foreign country) Illinois					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John M. Shields					14. MOTHER'S MAIDEN NAME Mary Kinman														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WWII		16. SOCIAL SECURITY NO. Unknown					16. SOCIAL SECURITY NO. (W) Mrs. Ethel B. Shields, same as #2 above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION 420.0 DUE TO (LEFT CORONARY ARTERY) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from July 16 , 19 59 , to July 16 , 19 59 , that I last saw the deceased alive on July 16 , 19 59 , and that death occurred at 1:03P M, from the causes and on the date stated above.														ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE H. S. IRONS					M.D. U. S. Naval Hospital					7-16-59									
PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN					Bethesda 14, Maryland														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7-22-59					22c. NAME OF CEMETERY OR CREMATORY Arlington National					22d. LOCATION (City, town, or county) (State) Arlington Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE Baker & Son										ADDRESS Manassas, Virginia					24a. REC'D BY REGISTRAR DATE JUL 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

10180
10180

CERTIFICATE OF DEATH

10180

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESSES: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF MINISTER: [illegible]
SIGNATURE OF CLERGYMAN: [illegible]
SIGNATURE OF CHURCH OFFICER: [illegible]
SIGNATURE OF BURIAL OFFICER: [illegible]
SIGNATURE OF FUNERAL HOME: [illegible]
SIGNATURE OF HEALTH OFFICER: [illegible]
SIGNATURE OF VITALS OFFICER: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
SIGNATURE OF CLERK: [illegible]
SIGNATURE OF ASSISTANT CLERK: [illegible]
SIGNATURE OF RECEPTIONIST: [illegible]
SIGNATURE OF TELEPHONE OPERATOR: [illegible]
SIGNATURE OF MAIL ROOM: [illegible]
SIGNATURE OF RECORDS SECTION: [illegible]
SIGNATURE OF IDENTIFICATION SECTION: [illegible]
SIGNATURE OF LABORATORY: [illegible]
SIGNATURE OF RADIOLOGY: [illegible]
SIGNATURE OF PATHOLOGY: [illegible]
SIGNATURE OF ANATOMY: [illegible]
SIGNATURE OF PHYSIOLOGY: [illegible]
SIGNATURE OF PSYCHOLOGY: [illegible]
SIGNATURE OF SOCIOLOGY: [illegible]
SIGNATURE OF ANTHROPOLOGY: [illegible]
SIGNATURE OF LINGUISTICS: [illegible]
SIGNATURE OF HISTORY: [illegible]
SIGNATURE OF GEOGRAPHY: [illegible]
SIGNATURE OF POLITICAL SCIENCE: [illegible]
SIGNATURE OF ECONOMICS: [illegible]
SIGNATURE OF LAW: [illegible]
SIGNATURE OF MEDICINE: [illegible]
SIGNATURE OF NURSING: [illegible]
SIGNATURE OF PHARMACY: [illegible]
SIGNATURE OF DENTISTRY: [illegible]
SIGNATURE OF VETERINARY MEDICINE: [illegible]
SIGNATURE OF AGRICULTURE: [illegible]
SIGNATURE OF FISHERIES: [illegible]
SIGNATURE OF FORESTRY: [illegible]
SIGNATURE OF MINING: [illegible]
SIGNATURE OF METALLURGY: [illegible]
SIGNATURE OF CHEMISTRY: [illegible]
SIGNATURE OF PHYSICS: [illegible]
SIGNATURE OF MATHEMATICS: [illegible]
SIGNATURE OF ENGINEERING: [illegible]
SIGNATURE OF ARCHITECTURE: [illegible]
SIGNATURE OF DESIGN: [illegible]
SIGNATURE OF ARTS: [illegible]
SIGNATURE OF LETTERS: [illegible]
SIGNATURE OF SCIENCE: [illegible]
SIGNATURE OF TECHNOLOGY: [illegible]
SIGNATURE OF INNOVATION: [illegible]
SIGNATURE OF RESEARCH: [illegible]
SIGNATURE OF DEVELOPMENT: [illegible]
SIGNATURE OF PROGRESS: [illegible]
SIGNATURE OF FUTURE: [illegible]

DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESSES: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF MINISTER: [illegible]
SIGNATURE OF CLERGYMAN: [illegible]
SIGNATURE OF CHURCH OFFICER: [illegible]
SIGNATURE OF BURIAL OFFICER: [illegible]
SIGNATURE OF FUNERAL HOME: [illegible]
SIGNATURE OF HEALTH OFFICER: [illegible]
SIGNATURE OF VITALS OFFICER: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
SIGNATURE OF CLERK: [illegible]
SIGNATURE OF ASSISTANT CLERK: [illegible]
SIGNATURE OF RECEPTIONIST: [illegible]
SIGNATURE OF TELEPHONE OPERATOR: [illegible]
SIGNATURE OF MAIL ROOM: [illegible]
SIGNATURE OF RECORDS SECTION: [illegible]
SIGNATURE OF IDENTIFICATION SECTION: [illegible]
SIGNATURE OF LABORATORY: [illegible]
SIGNATURE OF RADIOLOGY: [illegible]
SIGNATURE OF PATHOLOGY: [illegible]
SIGNATURE OF ANATOMY: [illegible]
SIGNATURE OF PHYSIOLOGY: [illegible]
SIGNATURE OF PSYCHOLOGY: [illegible]
SIGNATURE OF SOCIOLOGY: [illegible]
SIGNATURE OF ANTHROPOLOGY: [illegible]
SIGNATURE OF LINGUISTICS: [illegible]
SIGNATURE OF HISTORY: [illegible]
SIGNATURE OF GEOGRAPHY: [illegible]
SIGNATURE OF POLITICAL SCIENCE: [illegible]
SIGNATURE OF ECONOMICS: [illegible]
SIGNATURE OF LAW: [illegible]
SIGNATURE OF MEDICINE: [illegible]
SIGNATURE OF NURSING: [illegible]
SIGNATURE OF PHARMACY: [illegible]
SIGNATURE OF DENTISTRY: [illegible]
SIGNATURE OF VETERINARY MEDICINE: [illegible]
SIGNATURE OF AGRICULTURE: [illegible]
SIGNATURE OF FISHERIES: [illegible]
SIGNATURE OF FORESTRY: [illegible]
SIGNATURE OF MINING: [illegible]
SIGNATURE OF METALLURGY: [illegible]
SIGNATURE OF CHEMISTRY: [illegible]
SIGNATURE OF PHYSICS: [illegible]
SIGNATURE OF MATHEMATICS: [illegible]
SIGNATURE OF ENGINEERING: [illegible]
SIGNATURE OF ARCHITECTURE: [illegible]
SIGNATURE OF DESIGN: [illegible]
SIGNATURE OF ARTS: [illegible]
SIGNATURE OF LETTERS: [illegible]
SIGNATURE OF SCIENCE: [illegible]
SIGNATURE OF TECHNOLOGY: [illegible]
SIGNATURE OF INNOVATION: [illegible]
SIGNATURE OF RESEARCH: [illegible]
SIGNATURE OF DEVELOPMENT: [illegible]
SIGNATURE OF PROGRESS: [illegible]
SIGNATURE OF FUTURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8084

CERTIFICATE OF DEATH

08181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>3716 Quincy Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Washington Singley</u>		4. DATE OF DEATH Month Day Year <u>July 20 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11. BIRTHPLACE (State or foreign country) <u>Herrnberg, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Stephen Singley</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Klase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>171-63-2636</u>	
17. INFORMANT <u>Son - Mr. Donald Singley</u>		Address <u>10604 Lester St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Case cleared with Corona Broschart.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> , to <u>7/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/20</u> , 19 <u>59</u> , and that death occurred at <u>6:50 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>7/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 22, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE'S CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

2. *Journal of the American Medical Association* 277:1025-1026, 1997.

8200

CERTIFICATE OF DEATH

Reg. Dist. No.

08182

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle F Last SMITH		4. DATE OF DEATH Month July Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Code Clerk		12. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
13. BIRTHPLACE (State or foreign country) Indiana		14. CITIZEN OF WHAT COUNTRY? U. S.	
15. FATHER'S NAME George Smith		16. MOTHER'S MAIDEN NAME Liza ?	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		18. SOCIAL SECURITY NO. No	
19. INFORMANT Daughter		Address Mrs. Ethel S. Brimmer	
20. SAME AS ITEM #2 Same as Item #2			
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Stroke (sunstroke) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension With Cardiac Decompensation DUE TO (c) Insulation		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5/1952 , to Death , 19 59 , that I last saw the deceased alive on 6/30/1959 , and that death occurred at 72 South 17th St , from the causes and on the date stated above.			
ACTUAL SIGNATURE WR Strace		ADDRESS (Street, city or town, state) 3408 Wisconsin Ave N.W.	
PHYSICIAN'S NAME (Type) W. R. STOVALL		DATE SIGNED July 1, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR JUL 2 '59	
24b. REGISTRAR'S SIGNATURE C. L. K. K.			

1

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Bellevue

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8093

CERTIFICATE OF DEATH

Reg. Dist. No.

08183

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 40 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Van Buren Street.,				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26 d. STREET ADDRESS 315 Van Buren Street., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SAMUEL Last SMITH			4. DATE OF DEATH Month July Day 22 Year 19 59				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1882	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S. A.			13. FATHER'S NAME John Smith				
14. MOTHER'S MAIDEN NAME Nancy Shorter			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			INFORMANT Address Mrs. Rosalie M. Campbell Item 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic Interstitial Nephritis DUE TO (c) Congestive heart failure					INTERVAL BETWEEN ONSET AND DEATH 5 years + 3 years + 2 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Aug , 19 54 , to July , 19 59 , that I last saw the deceased alive on 7-22 , 19 59 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 61 R St NE DATE SIGNED 7/24/59							
ACTUAL SIGNATURE Calvin B. ReCompte M.D.		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/59	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		22d. LOCATION (City, town, or county) (State) Rockville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saunders ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR AUG 28 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1913

CENTRAL OF DEATH

2022



LIBRARY

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1913

[Faint, mostly illegible text and markings covering the lower half of the page, possibly bleed-through or very faded print.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08184

8201

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vivienne Frances Sommers			4. DATE OF DEATH Month 7/ Day 16/ Year 19 59				
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/02		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jerome Crowley				14. MOTHER'S MAIDEN NAME Anna Matilda Sanberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-12-6248		17. INFORMANT Carl P. Sommers, Ashton, Maryland (Route # 1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 weekss 2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from may , 19 59 , to July 16 , 19 59 , that I last saw the deceased alive on July 15 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Md. DATE SIGNED 7/16/59 ACTUAL SIGNATURE Richard A. Yates PHYSICIAN'S NAME (Type) Richard A. Yates							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/20/59		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Ziska				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR JUL 20 1959	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kious			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8202

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Spottsylvania			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS Route #3, Box 216A							
3. NAME OF DECEASED (Type or print) First Richard Middle Dale Last STALEY				4. DATE OF DEATH Month July Day 2 Year 19 59			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-55	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lloyd STALEY				14. MOTHER'S MAIDEN NAME Doris DALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL Heart Disease 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (CARDIAC ARREST - POST operative) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 23 , 19 59 , to July 2 , 19 59 , that I last saw the deceased alive on July 2 , 19 59 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 7-2-59							
ACTUAL SIGNATURE Douglas R. Koth M.D.							
PHYSICIAN'S NAME (Type) Douglas R. KOTH, LT, MC, USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home				24a. REC'D BY REGISTRAR JUL 7 1959		24b. REGISTRAR'S SIGNATURE Robert A. Thomas	
ADDRESS 2847 Wilson Blvd., Arlington, VA							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8203

CERTIFICATE OF DEATH

08186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3			
c. LENGTH OF STAY in 1b 50 days				d. STREET ADDRESS 1508 North Greenbrier Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Pauline Last Stoops		4. DATE OF DEATH Month July Day 29 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1902	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William A. Johnson				14. MOTHER'S MAIDEN NAME Emma Hershman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphangitic Spread of Carcinoma to Lung DUE TO (c) Carcinoma of the Breast						INTERVAL BETWEEN ONSET AND DEATH 7 Weeks 7 Weeks 8 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9 , 19 59 , to July 29 , 19 59 , that I last saw the deceased alive on July 29 , 19 59 , and that death occurred at 5:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7/30/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Gordon C. Sharp M.D.							
PHYSICIAN'S NAME (Type) GORDON C. SHARP, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 7/30/59		22c. NAME OF CEMETERY OR CREMATORY Crown View Cemetery		22d. LOCATION (City, town, or county) (State) Sheridan, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8204

Items 3,11 FilmG246 7-31-59 et
Items 2,11 FilmG254 1-20-60 et

CERTIFICATE OF DEATH

08187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chevy Chase 15,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bates</u> First <u>Nitchell</u> Middle <u>(Stovall)</u> Last <u>Stovall</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn's, Kentucky</u>	
13. FATHER'S NAME <u>Wm H Stovall</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Bales</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>261-32-4342</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 23, 1959</u> to <u>July 23, 1959</u> that I last saw the deceased alive on <u>July 23, 1959</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		ADDRESS (Street, city or town, state) <u>7852 16th St NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		DATE SIGNED <u>7/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I, W. Mitchell,
 of the County of Albany,
 do hereby certify that on the 11th day of July,
 1912, at Albany, New York,
 died Robert Mitchell,
 son of Robert Mitchell and Elizabeth Mitchell,
 born 1848 at Albany, New York.
 Cause of death Old age.
 Buried at Albany, New York, in the Albany Cemetery.
 Witness my hand and seal of office this 11th day of July, 1912.
W. Mitchell
 Registrar

Attest:
W. Mitchell
 Registrar
 July 11, 1912

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G244 7-15-59 et

8205

CERTIFICATE OF DEATH

08188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery Fulton		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ McLean 83X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simson's Rest Home		e. STREET ADDRESS 2104 Sorrell Street									
3. NAME OF DECEASED (Type or print) RICHARD HENRY TALBOTT		First		Middle		Last		4. DATE OF DEATH July 7 19 59		Month Day Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1867 91		9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired foreman of Carpenters - Pa. Railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Richard William Talbott		14. MOTHER'S MAIDEN NAME Deliah Bayliss									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Allen S. Talbott Allen S. Talbott		Address Deale, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aretriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 20 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked secondary anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 3, 19 59 , to July 7, 19 59 , that I last saw the deceased alive on July 6, 19 59 , and that death occurred at 12:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-7-59		ACTUAL SIGNATURE Charles S. Whitaker, M.D.									
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		Clarksville, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF July 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Lee (mrs)		ADDRESS 2847 Wilson Blvd., Arlington, Va.		24a. REC'D BY REGISTRAR JUL 10 '59		24b. REGISTRAR'S SIGNATURE Charles L. Frazier					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

1918

1918

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8206

CERTIFICATE OF DEATH

Reg. Dist. No.

08189

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1132 West Wakefield Drive	
3. NAME OF DECEASED (Type or print) First Mary Middle (none) Last Tolin		4. DATE OF DEATH Month July Day 17 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1921
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael J. Shiel		14. MOTHER'S MAIDEN NAME Catherine Delaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease: mitral valvulitis 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left hemithorax Status post operative repair 7/16/59: Acute & chronic congestion in lungs & liver			INTERVAL BETWEEN ONSET AND DEATH 26 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 28 , 19 59 , to July 17 , 19 59 , that I last saw the deceased alive on July 17 , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 7-18-59 ACTUAL SIGNATURE Joseph W. Gilbert, Jr. M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Joseph W. Gilbert, Jr., M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF July 21-59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) 71 Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE St. H. Demaine Jr.		ADDRESS Alex, Va.	24a. REC'D BY REGISTRAR DATE JUL 21 '59
		24b. REGISTRAR'S SIGNATURE Charles S. Howard	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John W. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1885</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>Jan 25, 1945</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John W. Smith</u></p>		<p>10. Signature of registrar: <u>John W. Smith</u></p>	
<p>11. Name of hospital: <u>St. Louis Hospital</u></p>		<p>12. Name of doctor: <u>John W. Smith</u></p>	
<p>13. Name of nurse: <u>John W. Smith</u></p>		<p>14. Name of attendant: <u>John W. Smith</u></p>	
<p>15. Name of undertaker: <u>John W. Smith</u></p>		<p>16. Name of funeral home: <u>John W. Smith</u></p>	
<p>17. Name of cemetery: <u>John W. Smith</u></p>		<p>18. Name of burial place: <u>John W. Smith</u></p>	
<p>19. Name of interment: <u>John W. Smith</u></p>		<p>20. Name of monument: <u>John W. Smith</u></p>	
<p>21. Name of monument: <u>John W. Smith</u></p>		<p>22. Name of monument: <u>John W. Smith</u></p>	
<p>23. Name of monument: <u>John W. Smith</u></p>		<p>24. Name of monument: <u>John W. Smith</u></p>	
<p>25. Name of monument: <u>John W. Smith</u></p>		<p>26. Name of monument: <u>John W. Smith</u></p>	
<p>27. Name of monument: <u>John W. Smith</u></p>		<p>28. Name of monument: <u>John W. Smith</u></p>	
<p>29. Name of monument: <u>John W. Smith</u></p>		<p>30. Name of monument: <u>John W. Smith</u></p>	
<p>31. Name of monument: <u>John W. Smith</u></p>		<p>32. Name of monument: <u>John W. Smith</u></p>	
<p>33. Name of monument: <u>John W. Smith</u></p>		<p>34. Name of monument: <u>John W. Smith</u></p>	
<p>35. Name of monument: <u>John W. Smith</u></p>		<p>36. Name of monument: <u>John W. Smith</u></p>	
<p>37. Name of monument: <u>John W. Smith</u></p>		<p>38. Name of monument: <u>John W. Smith</u></p>	
<p>39. Name of monument: <u>John W. Smith</u></p>		<p>40. Name of monument: <u>John W. Smith</u></p>	
<p>41. Name of monument: <u>John W. Smith</u></p>		<p>42. Name of monument: <u>John W. Smith</u></p>	
<p>43. Name of monument: <u>John W. Smith</u></p>		<p>44. Name of monument: <u>John W. Smith</u></p>	
<p>45. Name of monument: <u>John W. Smith</u></p>		<p>46. Name of monument: <u>John W. Smith</u></p>	
<p>47. Name of monument: <u>John W. Smith</u></p>		<p>48. Name of monument: <u>John W. Smith</u></p>	
<p>49. Name of monument: <u>John W. Smith</u></p>		<p>50. Name of monument: <u>John W. Smith</u></p>	
<p>51. Name of monument: <u>John W. Smith</u></p>		<p>52. Name of monument: <u>John W. Smith</u></p>	
<p>53. Name of monument: <u>John W. Smith</u></p>		<p>54. Name of monument: <u>John W. Smith</u></p>	
<p>55. Name of monument: <u>John W. Smith</u></p>		<p>56. Name of monument: <u>John W. Smith</u></p>	
<p>57. Name of monument: <u>John W. Smith</u></p>		<p>58. Name of monument: <u>John W. Smith</u></p>	
<p>59. Name of monument: <u>John W. Smith</u></p>		<p>60. Name of monument: <u>John W. Smith</u></p>	
<p>61. Name of monument: <u>John W. Smith</u></p>		<p>62. Name of monument: <u>John W. Smith</u></p>	
<p>63. Name of monument: <u>John W. Smith</u></p>		<p>64. Name of monument: <u>John W. Smith</u></p>	
<p>65. Name of monument: <u>John W. Smith</u></p>		<p>66. Name of monument: <u>John W. Smith</u></p>	
<p>67. Name of monument: <u>John W. Smith</u></p>		<p>68. Name of monument: <u>John W. Smith</u></p>	
<p>69. Name of monument: <u>John W. Smith</u></p>		<p>70. Name of monument: <u>John W. Smith</u></p>	
<p>71. Name of monument: <u>John W. Smith</u></p>		<p>72. Name of monument: <u>John W. Smith</u></p>	
<p>73. Name of monument: <u>John W. Smith</u></p>		<p>74. Name of monument: <u>John W. Smith</u></p>	
<p>75. Name of monument: <u>John W. Smith</u></p>		<p>76. Name of monument: <u>John W. Smith</u></p>	
<p>77. Name of monument: <u>John W. Smith</u></p>		<p>78. Name of monument: <u>John W. Smith</u></p>	
<p>79. Name of monument: <u>John W. Smith</u></p>		<p>80. Name of monument: <u>John W. Smith</u></p>	
<p>81. Name of monument: <u>John W. Smith</u></p>		<p>82. Name of monument: <u>John W. Smith</u></p>	
<p>83. Name of monument: <u>John W. Smith</u></p>		<p>84. Name of monument: <u>John W. Smith</u></p>	
<p>85. Name of monument: <u>John W. Smith</u></p>		<p>86. Name of monument: <u>John W. Smith</u></p>	
<p>87. Name of monument: <u>John W. Smith</u></p>		<p>88. Name of monument: <u>John W. Smith</u></p>	
<p>89. Name of monument: <u>John W. Smith</u></p>		<p>90. Name of monument: <u>John W. Smith</u></p>	
<p>91. Name of monument: <u>John W. Smith</u></p>		<p>92. Name of monument: <u>John W. Smith</u></p>	
<p>93. Name of monument: <u>John W. Smith</u></p>		<p>94. Name of monument: <u>John W. Smith</u></p>	
<p>95. Name of monument: <u>John W. Smith</u></p>		<p>96. Name of monument: <u>John W. Smith</u></p>	
<p>97. Name of monument: <u>John W. Smith</u></p>		<p>98. Name of monument: <u>John W. Smith</u></p>	
<p>99. Name of monument: <u>John W. Smith</u></p>		<p>100. Name of monument: <u>John W. Smith</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8207

08190

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Hartford</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hauve de Grace</i> 12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Townsend</i> Last <i>July</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 25 1887</i>
9. AGE (In years, last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Granville</i>		14. MOTHER'S MAIDEN NAME <i>Martha Dwayne</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Thelma Shipley</i> Address <i>Hauve de Grace md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 446X DUE TO (b) <i>Nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>Months</i> <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/30</i> , 19 <i>59</i> , to <i>7-1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/30</i> , 19 <i>59</i> , and that death occurred at <i>11:30</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J.M. Bird</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>July 7 1959</i>	
PHYSICIAN'S NAME (Type) <i>J.M. Bird</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Garage Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Garage Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Canalehan</i>		ADDRESS <i>Garage Md</i>	
24a. REC'D BY REGISTRAR <i>DATE JUL 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital's attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08191
Kensington, Md. 8208										CERTIFICATE OF DEATH
										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY MONTGOMERY Kensington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery 2915 E. St. N.W.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ken. Gardens Sanitarium			c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS 10006 Robin Road					
3. NAME OF DECEASED (Type or print) Mrs Margaret First S. Middle Vitale Last					4. DATE OF DEATH Month 7 Day 8 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 15, 1888 yrs.		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Wash. D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jonathon Dickerton					14. MOTHER'S MAIDEN NAME Mary Longton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. none		INFORMANT Samuel A Vitale		Address 10006 Robin Rd Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —										INTERVAL BETWEEN ONSET AND DEATH months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Time 27, 19 59 to July 8, 19 59 that I last saw the deceased alive on July 8, 19 59 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. Has been under care of my associate, Dr. T. H. Hartman for at least a month.										
ACTUAL SIGNATURE B. Buchanan					M.D. 1834 Eye St. N.W. Wash. D.C.		DATE SIGNED			
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/59		22c. NAME OF CEMETERY OR CREMATORY State of Deacon Cemetery			22d. LOCATION (City, town, or county) (State) Montgomery County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler & Sons Inc.					ADDRESS 1756 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR Aug 13 59		24b. REGISTRAR'S SIGNATURE	

Richmond, Md.

Montgomery, Md. Richmond, Md.
New Garden, Virginia 28 days

Female white
Mrs. Ward

2

5/19/95

✓ March 12

✓

8

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08192

8209

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neelsville				c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Home of Rest				d. STREET ADDRESS 1215 Fern Street, N. W.			
3. NAME OF DECEASED (Type or print) First Annie Middle M. Last Walker				4. DATE OF DEATH Month July Day 6 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1868	
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Richard A. Walker				14. MOTHER'S MAIDEN NAME Sallie Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Scott Walker, Jr. Address 416 Hillmoor Drive Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 16 years				INTERVAL BETWEEN ONSET AND DEATH 16 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/15 , 19 57 , to 7/6 , 19 59 , that I last saw the deceased alive on 7/6 , 19 59 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state), Homascus, Md. DATE SIGNED 7/6/59 ACTUAL SIGNATURE James P. Kerr M.D. PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/9/59		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc. ADDRESS Silver Spring, Md. Raymond A. Ziska				24a. REC'D BY REGISTRAR JUL 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08193

8210

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>128 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u> d. STREET ADDRESS <u>5618 Wilson Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilton Harris Wallace</u>			4. DATE OF DEATH Month Day Year <u>July 3, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1898</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>3</u> <u>1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law Offices</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Braxton C. Wallace</u>			14. MOTHER'S MAIDEN NAME <u>Ella Harris</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>578-14-8943</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension 2° Aspiration</u> <u>205X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mycosis Fungoides</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>February 25, 1959</u> to <u>July 3, 1959</u> , that I last saw the deceased alive on <u>July 3, 1959</u> , and that death occurred at <u>2:50 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7-4-59</u>					
ACTUAL SIGNATURE <u>Charles E. Mengel</u>		M.D. <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>Ch Charles E. Mengel, M. D.</u>		<u>National Institutes of Health</u>			
<u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county)		(State) <u>Prince Georges County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St., N.W.</u>			24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carling S. Hines</u>

CERTIFICATE OF DEATH

82

NAME OF DECEASED: *John W. Smith*
 SEX: *M* AGE: *65* DATE OF BIRTH: *1885*
 PLACE OF BIRTH: *MD* OCCUPATION: *Farmer*
 MARITAL STATUS: *Married* DECEASED AT: *Home*
 DATE OF DEATH: *1945* TIME OF DEATH: *10:00 AM*
 CAUSE OF DEATH: *Heart Disease*
 PLACE OF DEATH: *Home* COUNTY: *MD*
 CITY: *Baltimore* STATE: *MD*
 SIGNATURE OF DECEASED: _____
 SIGNATURE OF WITNESSES: _____
 SIGNATURE OF PHYSICIAN: _____
 SIGNATURE OF CORONER: _____
 SIGNATURE OF REGISTRAR: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8211 CERTIFICATE OF DEATH

Reg. Dist. No.

08194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Germantown</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Neal</u> Last <u>Wallich</u>		d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Harding</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive pneumonia</u> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sumulent bronchitis</u> DUE TO (c) <u>organic dementia, myocardial degeneration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10-12 hours</u> <u>3-4 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis of central nervous system</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct-21-1958</u> to <u>July-30-1959</u> , that I last saw the deceased alive on <u>July-30-1959</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>7-Brooks Ave., Gaithersburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Miller, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Highland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Multiple sclerosis of central nervous system
 Chronic, progressive, degenerative
 Spinal cord, myeloid degeneration
 Spinal cord, myeloid degeneration
 Spinal cord, myeloid degeneration

8-4 day
 10-15 hours

John - 30 - 20
 William F. Miller
 2-Bricker Ave.
 255-21-28
 255-21-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8212 CERTIFICATE OF DEATH

Reg. Dist. No.

08195

<p>1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY</p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULTON, MD.</p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.</p>				<p>d. STREET ADDRESS LIME KILN ROAD</p>			
<p>3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FREDERICK WALTERS</p>				<p>4. DATE OF DEATH Month Day Year JULY 12 1959</p>			
<p>5. SEX MALE</p>		<p>6. COLOR OR RACE WHITE</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 1-31-1878</p>	
<p>9. AGE (In years lost birthday) yrs. 81</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS. Months Days Hours Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARM HAND</p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY FARM</p>		<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>			
<p>13. FATHER'S NAME GEORGE WALTERS</p>				<p>14. MOTHER'S MAIDEN NAME CAROLINE DAYOFF</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO</p>				<p>16. SOCIAL SECURITY NO. GEORGE HENRY WALTERS</p>			
<p>17. INFORMANT WALTERS</p>				<p>Address LIME KILN ROAD FULTON, MD.</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery occlusion DUE TO (c) 12 hours 12 hours</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work</p>			
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I attended the deceased from March 7, 19 57, to July 12, 19 59, that I last saw the deceased alive on July 12, 19 59, and that death occurred at 11:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 7-13-59</p>							
<p>ACTUAL SIGNATURE Charles S. Whitaker, M.D.</p>				<p>PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>22b. DATE THEREOF 7/14/59</p>		<p>22c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEM. GLENELG MD.</p>		<p>22d. LOCATION (City, town, or county) (State)</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE Edith Canabon Laurel, Md.</p>				<p>24a. REC'D BY REGISTRAR DATE JUL 16 '59</p>		<p>24b. REGISTRAR'S SIGNATURE Arthur S. Kraw</p>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BIRTH CERTIFICATE OF DEATH

THE STATE OF MARYLAND, DISTRICT OF

COUNTY OF MONTGOMERY, WITNESSETH THAT JOHN

WALTERS, of the County of MONTGOMERY, State of MARYLAND,

MADE WITHESS, on the 1-1-1878, at

NATURAL-BORN FREE, (Age 31-11-10)

GEORGE WALTERS, CAROLINE DAYTON
GEORGE HENRY WALTERS, JR.

WITNESSES: JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

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JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

JOHN C. WALTERS, JR. and JOHN C. WALTERS, JR.

8213 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eithersburg</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home for the Aged Inc</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nettie Irene Welch</u>		4. DATE OF DEATH <u>July 6 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Clements</u>		14. MOTHER'S MAIDEN NAME <u>Emily Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Asbury Methodist Home Eithersburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pneumonia</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-18 1956</u> , to <u>7-6 1959</u> , that I last saw the deceased alive on <u>7-4 1959</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) <u>10128 CEDAR LANE KENSINGTON, Md</u>	
PHYSICIAN'S NAME (Type) <u>Sarah Elizabeth Glover</u>		DATE SIGNED <u>7-6-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Funeral Home, Catonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 10 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician's signature.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1925</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1948</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1970</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>16. OFFICIAL USE <i>[Blank]</i></p>	

MAILED
1971
JAN 15

8214

CERTIFICATE OF DEATH

08197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Hamburg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamburg</u> 69x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp.</u>		d. STREET ADDRESS <u>16 Woodview Court</u>	
3. NAME OF DECEASED (Type or print) <u>DOROTHEA WESTERMAN</u>		4. DATE OF DEATH <u>July 22 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Blumenau, Brazil</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Sandrecki</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Groben</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Skubut Steiner - Mount Airy, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 443.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auricular fibrillation</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension; terminal pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-15, 1959</u> , to <u>7-22, 1959</u> , that I last saw the deceased alive on <u>7-21, 1959</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sani Okutman</u> M.D.		ADDRESS (Street, city or town, state) <u>Central Ave. Sykesville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sani A. Okutman</u>		DATE SIGNED <u>7-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Neustadt</u>	22d. LOCATION (City, town, or county) (State) <u>Neustadt, Ontario</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur H. Haight</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Haight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG244 7-13-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08198

8215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Orlando, Route # 3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando, Route # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>The Wilcox Grove</u>	
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>B-</u> Last <u>WILCOX</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1891</u>
9. AGE (In years last birthday) <u>67 yrs.</u>		IF UNDER 1 YEAR Months <u>67</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Citrus Fruit Grower</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josiah Wilcox</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Osbourn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I & WW II</u>		16. SOCIAL SECURITY NO. <u>266-56-4280</u>	
17. INFORMANT <u>Adele C. Wilcox</u>		Address <u>RFD #3 Orlando, Fla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>A.S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>4 Days</u> <u>3 Yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>59</u> , to <u>3 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>59</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R. Shuman</u>		DATE SIGNED <u>11/11 Army Navy Dr.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH SHUMAN</u>		<u>Arlington Va.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Cawley Sons</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>	
ADDRESS <u>1756 Pa. Ave., N.W. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1913

1913

1913

1913

VS A15 (4)
15M 10/57

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

8811

<p>1. Name of deceased: <i>FRANCIS W. WILSON</i></p>	
<p>2. Date of death: <i>April 11, 1934</i></p>	
<p>3. Place of death: <i>Home</i></p>	
<p>4. Age: <i>62</i></p>	
<p>5. Sex: <i>Male</i></p>	
<p>6. Race: <i>White</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>	
<p>8. Signature of physician: <i>[Signature]</i></p>	
<p>9. Signature of registrar: <i>[Signature]</i></p>	
<p>10. Date of filing: <i>April 15, 1934</i></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing in "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 08200										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Hts.				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7000 Block McArthur Blvd.					d. STREET ADDRESS 6400 2nd Place N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elbert T Williamson					4. DATE OF DEATH Month July Day 22 Year 1959					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/1904		9. AGE (In years last birthday) 54 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant				10b. KIND OF BUSINESS OR INDUSTRY George Town, Md.		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elmer E Williamson					14. MOTHER'S MAIDEN NAME Harnett Phillips					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Luella L. Williamson Address 6400 2nd Pl NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning and 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) strangulation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in closed car with a light undershirt tied tightly around neck. Empty vial found in car.										
20c. TIME OF INJURY Month, Day, Year Hour — o. m. — p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) -- -- --		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Fr nk J, Broschart					DATE SIGNED 7/22/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat			22d. LOCATION (City, town, or county) (State) Arlington Va			
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home					ADDRESS 4812 Ya Ave NW		24a. REC'D BY REGISTRAR DATE JUL 29 '59		24b. REGISTRAR'S SIGNATURE Charles E. Harris	

1

821

099

2

D.C.

8218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>M.D.</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORBECK</u>				c. LENGTH OF STAY IN 1b <u>15 MO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN BELT</u> <u>1623-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PHILomena's HOME</u>				d. STREET ADDRESS <u>224. CRESCENT RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRIETTA</u> Middle <u>A.</u> Last <u>WILSON</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1891</u> 9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHAS PATCLIFF</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JAMES A WILSON</u>		Address <u>224 CRESCENT RD. GREENBELT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yr.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1, 1958</u> , to <u>July 20, 1959</u> , that I last saw the deceased alive on <u>July 10, 1959</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia Ave. Silver Spring, Md.</u> DATE SIGNED <u>Arthur L. Kneiss</u>							
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch s Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08202

8219 **CERTIFICATE OF DEATH**

Reg. Dist. No.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Montgomery</i>	STATE <i>D.C.</i> COUNTY		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Bethesda</i>	LENGTH OF STAY (in this place) <i>5 day</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>WASH.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>SUBURBAN</i>	STREET ADDRESS (If rural give location) <i>4811 DAVENPORT ST.</i>		
3. NAME OF DECEASED (Type or Print) <i>John J. Wilson</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>July 16 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>7-15-1888</i>
9. AGE last birthday <i>71</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. LAWYER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>CONN.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John J. Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Cogan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Hoop Records</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
157x IMMEDIATE CAUSE (A) <i>Respiratory Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hr</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Metastatic Carcinoma</i>		<i>6 ms.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Carcinoma of Pancreas</i>		<i>9 ms.</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 1959</i> , to <i>7/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7/15</i> , 19 <i>59</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Frank J. Jagers Jr.</i>		DATE SIGNED <i>7/16/59</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23. NAME OF CEMETERY OR CREMATORY <i>MT Olivet Cem. Wash. DC</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase</i>	
DATE <i>JUL 21 '59</i>		ADDRESS <i>Cherry Chase Fun. Home, Wash, DC</i>	

CERTIFICATE OF DEATH

Form No. 100

1. PLACE OF DEATH

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BURIAL

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CONSTABLE

18. SIGNATURE OF TOWN CLERK

19. SIGNATURE OF TOWN TREASURER

20. SIGNATURE OF TOWN ENGINEER

21. SIGNATURE OF TOWN SURVEYOR

22. SIGNATURE OF TOWN ASSESSOR

23. SIGNATURE OF TOWN COMMISSIONER

24. SIGNATURE OF TOWN BOARD OF SELECTMEN

25. SIGNATURE OF TOWN BOARD OF HEALTH

26. SIGNATURE OF TOWN BOARD OF EDUCATION

27. SIGNATURE OF TOWN BOARD OF FIRE

28. SIGNATURE OF TOWN BOARD OF POLICE

29. SIGNATURE OF TOWN BOARD OF CHURCH

30. SIGNATURE OF TOWN BOARD OF SCHOOL

31. SIGNATURE OF TOWN BOARD OF LITERARY

32. SIGNATURE OF TOWN BOARD OF ARTS

33. SIGNATURE OF TOWN BOARD OF MUSIC

34. SIGNATURE OF TOWN BOARD OF THEATRE

35. SIGNATURE OF TOWN BOARD OF CIRCUS

36. SIGNATURE OF TOWN BOARD OF FAIR

37. SIGNATURE OF TOWN BOARD OF RACE

38. SIGNATURE OF TOWN BOARD OF GAMES

39. SIGNATURE OF TOWN BOARD OF LOTTERY

40. SIGNATURE OF TOWN BOARD OF GAMING

41. SIGNATURE OF TOWN BOARD OF BETTING

42. SIGNATURE OF TOWN BOARD OF POOL

43. SIGNATURE OF TOWN BOARD OF CARDS

44. SIGNATURE OF TOWN BOARD OF DICE

45. SIGNATURE OF TOWN BOARD OF COIN

46. SIGNATURE OF TOWN BOARD OF TABLET

47. SIGNATURE OF TOWN BOARD OF BILLIARDS

48. SIGNATURE OF TOWN BOARD OF CROQUET

49. SIGNATURE OF TOWN BOARD OF GOLF

50. SIGNATURE OF TOWN BOARD OF TENNIS

51. SIGNATURE OF TOWN BOARD OF BASEBALL

52. SIGNATURE OF TOWN BOARD OF SOFTBALL

53. SIGNATURE OF TOWN BOARD OF BASKETBALL

54. SIGNATURE OF TOWN BOARD OF VOLLEYBALL

55. SIGNATURE OF TOWN BOARD OF HOCKEY

56. SIGNATURE OF TOWN BOARD OF RUGBY

57. SIGNATURE OF TOWN BOARD OF CRICKET

58. SIGNATURE OF TOWN BOARD OF FOOTBALL

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 RECEIVED
 MAY 10 1900
 DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8085

CERTIFICATE OF DEATH

Reg. Dist. No.

08203

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>1641-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>418 Prince George St</u>	
3. NAME OF DECEASED (Type or print) First <u>Lotty</u> Middle <u>(None)</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Millard</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-17, 1959</u> , to <u>7-19, 1959</u> , that I last saw the deceased alive on <u>7-19, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A W. DANISH</u>		DATE SIGNED <u>7-19-59</u>	
PHYSICIAN'S NAME (Type) <u>A W. DANISH</u>		ADDRESS (Street, city or town, state) <u>927 Parkway St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Calmar Maryland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. H. H. H.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. H. H.</u>	

8220

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <u>6709 Annan Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Wright</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/31/68</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Isaac Leeds</u>				14. MOTHER'S MAIDEN NAME <u>Florence Lippencott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Daughter (Same as Above)</u>				18. ADDRESS <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Congestive Heart Failure</u> <u>434.1</u> <u>Myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>2. Fr. Hip</u> <u>Left</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/11/59</u> to <u>7/23/59</u> , that I last saw the deceased alive on <u>7/23</u> , 19 <u>59</u> , and that death occurred at <u>6:35 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Mervin Gibson</u> M.D.				DATE SIGNED <u>1835 I St</u>			
PHYSICIAN'S NAME (Type) <u>Mervin Gibson</u>				ADDRESS (Street, city or town, state) <u>Wash. D.C</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	
22d. LOCATION (City, town, or county) <u>Lowson</u>				22e. (State) <u>md</u>		22f. (City, town, or county) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Jul 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll A. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart Notified

40804

CERTIFICATE OF DEATH

RECEIVED
MAY 10 1960
FBI - NEW YORK

STATE OF NEW YORK
COUNTY OF NEW YORK
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of May, 1960, at New York, New York, I examined the body of
[Name] [Address]
[Age] [Sex]
[Cause of Death]
[Signature]
[Date]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08205

8221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg d. STREET ADDRESS 110 North Frederick Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clintie Irene Yancey				4. DATE OF DEATH Month July Day 22 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus Winfield Devilbliss			14. MOTHER'S MAIDEN NAME Rachel Ruth Norwood				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Left Breast & Widespread Metastases 170x DUE TO Breast & Widespread Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Apr. 1953 , to July 22, 1959 , that I last saw the deceased alive on July 22, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED 7-22-59 ACTUAL SIGNATURE Jack Schumacher M.D. PHYSICIAN'S NAME (Type) Jack Schumacher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-59	22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg, Md.			24a. REC'D BY REGISTRAR DATE JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15M

8222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film 244 7-14-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5614 Jordon Road		d. STREET ADDRESS 5614 Jordon Road	
3. NAME OF DECEASED (Type or print) Clemence Robert First ZIMMERMANN Middle Last		4. DATE OF DEATH July 1, 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1888
9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 3 Days 22 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Consultation		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Robert Zimmerman		14. MOTHER'S MAIDEN NAME Anna Blum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Mrs. Meta Zimmerman - wife- Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - - - - - DUE TO (c) - - - - -		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - - - -			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED July 1, 1959	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-59	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24. REC'D BY REGISTRAR JUL 7 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Cecil L. K...	



1. Name of patient
2. Date of birth
3. Sex
4. Race
5. Religion
6. Education
7. Occupation
8. Marital status
9. Address
10. City
11. State
12. Zip
13. Date of admission
14. Date of discharge
15. Date of death
16. Cause of death
17. Place of death
18. Name of physician
19. Name of hospital
20. Name of attending physician
21. Name of consulting physician
22. Name of pathologist
23. Name of radiologist
24. Name of laboratory
25. Name of pharmacy
26. Name of dietitian
27. Name of nurse
28. Name of social worker
29. Name of chaplain
30. Name of other personnel

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: Robert A. Thompson
2. Date of birth: July 1, 1933
3. Sex: Male
4. Race: White
5. Religion: Methodist
6. Education: High School
7. Occupation: Teacher
8. Marital status: Married
9. Address: 1234 Main St.
10. City: Houston
11. State: Texas
12. Zip: 77001
13. Date of admission: July 1, 1955
14. Date of discharge: July 1, 1955
15. Date of death: July 1, 1955
16. Cause of death: Heart Disease
17. Place of death: Home
18. Name of physician: Dr. J. H. Smith
19. Name of hospital: St. Luke's Hospital
20. Name of attending physician: Dr. J. H. Smith
21. Name of consulting physician: Dr. J. H. Smith
22. Name of pathologist: Dr. J. H. Smith
23. Name of radiologist: Dr. J. H. Smith
24. Name of laboratory: Dr. J. H. Smith
25. Name of pharmacy: Dr. J. H. Smith
26. Name of dietitian: Dr. J. H. Smith
27. Name of nurse: Dr. J. H. Smith
28. Name of social worker: Dr. J. H. Smith
29. Name of chaplain: Dr. J. H. Smith
30. Name of other personnel: Dr. J. H. Smith